EXAMINING POLICE, HEALTH, AND MENTAL HEALTH CRISIS RESPONSE TEAMS

POLICE, HEALTH, AND MENTAL HEALTH CRISIS RESPONSE TEAMS

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A Thesis Submitted to the School of Graduate Studies in Partial Fulfilment of the Requirements for the Degree Doctor of Philosophy

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McMaster University DOCTOR OF PHILOSOPHY (2024) Hamilton, Ontario (Health Research Methods, Evidence, and Impact)

TITLE: Police, Health, and Mental Health Crisis Response Teams AUTHOR: Ania Theuer, MCA, MSW SUPERVISOR: Michael G. Wilson, PhD NUMBER OF PAGES: xiv, 222

Lay Abstract

Since deinstitutionalization, during which mental health patients were discharged into the community, this population has had more frequent encounters with police, contributing to criminalization and tragedies. They have also increasingly sought mental health crisis support in emergency departments. Police, health, and mental health crisis response teams (CRTs) have been implemented as an alternative response to people with mental health issues who are in crisis. To date, CRTs have been widely implemented but with little, mixed, and/or anecdotal evidence demonstrating their effectiveness. This dissertation contextualizes information about CRTs by presenting (a) a conceptual framework on CRTs, outlining the structural, system, and individual conditions under which CRTs are formed, their features, and outcomes; (b) a case study that examined under what conditions a CRT was developed and implemented in Hamilton, Canada; and (c) a critical discourse analysis of CRTs.

Abstract

Scarce community mental health resources have led to people in crisis (PIC) overusing the emergency department (ED) and encountering police more frequently. To divert PIC from the ED and criminal justice system, and support them in their community, police services have implemented crisis response teams (CRTs). CRTs refer to police, health and mental health crisis response. Evidence of CRTs' effectiveness in achieving their desired outcomes is limited, mixed, and/or anecdotal. I completed three studies using various theoretical and methodological approaches, which included: (a) a critical interpretative synthesis (CIS) of the conditions under which CRTs are formed, their features, and their outcomes; (b) a policy analysis using a case study design to examine how and why a CRT model was adopted in Hamilton, Canada; and (c) a what's the problem represented to be (WPR) critical policy analysis of why police are implicated in crisis response. The CIS presents a conceptual framework depicting how unresolved structural conditions produce system- and individual-level challenges. Second, the case study examines the mobile crisis rapid response team (MCRRT) development in Hamilton. The analysis shows that initiatives that incrementally expand on the boundaries of existing programs are likely to be adopted. Third, drawing on WPR, we excavate problem representations within policy and policy-related texts to understand why police-based CRTs are expanded in Ontario. When mental health is framed in terms of safety and implicated within discourses about risk and danger police intervention is legitimized. Collectively, these studies provide a theoretical framework connecting structural, system, and individual factors most relevant to CRTs; demonstrate that an incremental approach to CRT adoption did not disrupt existing system arrangements; and problematizations within government policies that legitimize police in mental health crisis response.

Acknowledgements

> "I want to I want to thank me for believing in me, I want to thank me for doing all this hard work, I want to thank me for having [barely any] days off, I want to thank me for never quittin', I want to thank me for just being me at all times".
> —Snoop Dogg

I take Snoop's speech as a reminder to myself about where I came from, a small village in Poland where higher education would only have been a dream, to what life in Canada became, a reality of the possibility to obtain higher education and this PhD. Through all the struggles, I have grown to become a critical thinker (and recognized that I have always been a critical thinker) and engage in the intellectual enterprise that could have never been. Along the way, I recognize that I did not do this alone, and I would like to thank the human beings who have been part of this journey and for which there is not enough space here to come close to expressing my gratitude.

Dla moich rodziców którzy chcieli dla nas dać możliwość na inne życie - lepsze życie z większymi możliwościami. Mam nadzieję że widząc Angelikę i mnie oraz was, efekt waszego poświęcenia. Dziękuję że nawet kiedy chciałam się poddać to daliście mi wsparcie że dam rady i nawet jeżeli bym zdecydowała że tej pracy nie skończę. Dziękuję za waszą cierpliwość kiedy zaszłam w swoje drogi, kiedy błądziłam i brak było cierpliwości.

Dr. Michael G. Wilson, my thesis supervisor: thank you is not enough to express my gratitude for your time, effort, guidance and everything in-between during the PhD process. Your humanity (besides your intellect, wisdom) is your best quality; your humanity is what helped me throughout this process.

Dr. Julia Abelson and Dr. Lauren Eisler, my thesis committee members: your time, dedication and belief in me as a doctoral student and scholar gave me the courage to keep going during challenging times. Moreover, together with Dr. Wilson, you 'saved my life'. That is, you recognized when it was time to take a break and normalized that for me. Without it, I would not have finished the PhD.

Dr. Ann DeShalit, my co-author, mentor and guide: I am grateful that in this journey, our paths have crossed. Your openness to work with me along with your encouragement and compassion reminded me of purpose to this work.

Dr. Jamie Livingston, my external examiner: It is truly my deepest gratitude to have you part of my work, my defence and in hopes of crossing paths in the transformative process.

Dr. Stacey Hannem: Who would have thought that all those years ago when I walked into your Cultural Criminology course, that today I would have the privilege to call you my mentor and friend. You are a human gift – your wisdom, life experiences, struggles and your strength are beyond admirable. You have been there for me throughout my PhD journey as a sounding board to my ideas, have challenged me to think beyond ways I only wished I could, and you continue

to critically engage me. I never imagined I come even close to your brilliance and drawing on your theory is only a small way I can demonstrate your academic influence.

Dr. Chris Bruckert: You have always been part of my work – I have never forgotten our conversations about CRTs and their problematics including after my journey took me to Mac. There is a lineage of influence, whether through words, ways of thinking and/or disrupting, that continues to have life and impact through those whom you've mentored. I am proud to be (whether invited or not lol) connected to it.

Dr. Katrin Roots: I appreciate the many conversations about the process of the PhD and your understanding of struggle in ways that provided clarity to the situation. I appreciate the time you took to navigate the most challenging of times, encouraging me to continue and sharing in the joys of small steps.

Dr. M. Raymond Izarali: I will never forget our conversations in your office about the 'wish' to do a PhD and your encouragement and belief that it can be a reality. I am so grateful that you haven't forgotten them and amidst some of my more challenging moments, you reminded me of these conversations. Thank you for remembering.

To the WLU OG's, Dr.'s Lauren Eisler, Tom Fleming, Ken Dowler, Dan Antonowicz: In many ways, you each opened the intellectual gateway 20 years ago when we met in your classes. Whether it was through your teaching, mentoring, and you just being your 'selves', you each ignited a spark I didn't even know was there and which drove (me nuts) in the best ways possible to continually build my knowledge.

Dr. Allen, I am grateful for your compassionate care; in my hardest struggles you believed in me and encouraged me to continue, and you did everything in your power to help me to find that courage. You did not give up on me, you helped me find the way and you told me that I came so far and that I could finish the PhD. I thank you for your compassion.

Lauren, my friend and mentor, 20 years ago when we formally met at the conference at YorkU and invited me to meet you at your office in GRH where you offered to mentor me, I never imagined that it would create a legacy. Our histories (what they were supposed to be) and our determination to alter the course forms this legacy. I could not have altered my course had I not met you, you became instrumental in showing me possibility to alter the course of history; your legacy continues through me. Together, you and John have been in my corner – always willing to listen, send courage my way and lovingly challenge me to consider alternatives. I am grateful for the many dinners and opportunities to work when times got rough.

Jowitka, this all began with you at Mohawk College when I decided I was 'only good enough' to stay in College and you nudged me, and didn't give up on nudging me, to apply to WLU Criminology. I remember you trying to reason with me in the most wonderful and caring way to give myself a chance and try and that you would be there with me and would help along the way – that I wouldn't be alone, we would do it together. And still, I said no (because many times in my life I reminded (mostly by educated men) that I was the stupid one that would never amount

to anything)). I am so deeply grateful that you kept encouraging me to see the possibility – thank you for your persistence. I am here because you were there.

Cass, as you have gotten to know me throughout this process, I appreciate the times when you reminded me that it's ok to take a break and regroup and then get back at it. And, for finding ways to get me out of the house when I insisted that staring at the screen will eventually mean words on page. I also appreciate that without knowing my work, you would ask "you finish that paper yet?" That always helped normalize this process somehow and take me out of the 'seriousness' of it all. Virginia Steele (still the best superhero name ever), thank you for your straight up advice when I needed to step outside of my own intellect. I especially thank you for our pre-defence conversation which was truly valuable, and which shaped my approach.

Patricia, when we first connected, I thought I lost 'everything', even myself and that I would not be able to find it. You created a space of safety – and showed me that even if I lost everything, I never lost my soul. You are one of the most incredible human beings I have ever met – it is an honor knowing you.

Kaitlin, I cannot imagine how I would've navigated many of the processes without your help and for being a sounding board as I went to hell and back. I appreciate your kindness toward me, our check-in chats and for just being here while worked my way through the challenges and the wins.

Karen, my shit getter together, the thoughts and words in this dissertation would not have been possible without you – at least not as flawless as they are had I not picked up the phone and called you. I thank you for all the time you took to turn my written ideas into material that would not cause people to want to rip their hair out.

Mike, Paulinka, Zeph, Paula (Alice), Judy, Adela, Gosia and fam – my friends who at various times throughout the PhD have come into my life and have been part of this journey. I am so grateful for your support. You have many times stuck by me when I needed to borrow your courage, challenged me to reframe the circumstances, made me laugh when I was down and cry when I needed to. You have seen me through the best and the worst, I thank you for being part of it all.

To my nephew, Adrianek – my hope is that this legacy is an example of possibilities. It is a piece of history that is your history that was possible because the course was altered. Your grandparents (babcie i dziadki) chartered the path for your parents, Angelika and Piotrek, as they are for you, so that you can create your future.

To those who endure: "Nolite te bastardes carborundorum."

—Margaret Atwood

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List of Abbreviations

3i+E:	Framework comprised of institutions, interests, and ideas and external factors
CAMH:	Centre for Addiction and Mental Health
CBT	Cognitive behavioural therapy
CIS:	Critical interpretive synthesis
CIT:	Crisis intervention team
CJS:	Criminal justice system
CMHA:	Canadian Mental Health Association
COAST:	Crisis Outreach and Support Team
CRT:	Crisis response teams
ED:	Emergency department
LHIN:	Local Health Integration Network
MCRRT:	Mobile Crisis Rapid Response Team
MCRT:	Mobile Crisis Response Team
MHA:	Mental Health Act
MOHLTC:	Ministry of Health and Long-Term Care
PIC:	People in crisis
PMI:	Person with mental illness
WPR:	What is the problem represented to be?

Declaration of Academic Achievement

This dissertation presents three original research studies (Chapters 2–4) as well as an introductory chapter (Chapter 1) and conclusion chapter (Chapter 5). Each of the three original research studies are co-authored and I, Ania Theuer, am the lead author on all five chapters. Details of the specific contributions for each study are outlined in the preface of the relevant chapter. I was responsible for conceptualizing the areas of focus for the dissertation, for its design, conducting data collection, analysis, and preparation of the written papers. My dissertation supervisor, Dr. Michael G. Wilson, and my committee members Dr. Julia Abelson and Dr. Lauren Eisler, contributed to the design, analysis, and synthesis in their areas of expertise related to each of the studies and provided feedback on written drafts. Dr. Ann De Shalit contributed to the analysis and synthesis of the third study (Chapter 4) and provided feedback on written drafts of the study. I also consulted with Dr. Adrian Guta during the early stages of the design of the third study (Chapter 4).

Chapter 1: Introduction

This doctoral dissertation comprises three original research studies exploring factors that contribute to crisis response teams (CRTs) being developed and implemented. This chapter presents an overview of police response to people with mental health issues and situates the dissertation within its broader context. I then address the aims of and rationale for the dissertation, including the methodological and theoretical approaches used in each of the three studies. Next, I discuss the anticipated substantive, methodological, and theoretical contributions. I conclude by locating myself within the dissertation as a researcher, first author, and main contributor to the dissertation, as well as a former practitioner in mental health crisis response.

Police Response to People With Mental Health Concerns

Globally, mental health continues to be the leading cause of disability, with nearly 450 million people experiencing mental illness (Centre for Addiction and Mental Health [CAMH], 2023).[1] In Canada, the issue is equally alarming with data indicating that one in two Canadians will experience a mental illness by age 40 (CAMH, 2023). All provinces have developed mental health policies and direction, however funding for mental health has continued to be a challenge (Bartram & Lurie, 2014). This includes the failed promise by the federal government to develop a permanently funded Canada Mental Health Transfer "to provinces and territories to assist in expanding free, accessible mental health and substance use health services" (Canadian Mental Health Association Simcoe County, 2023, para. 2) which was set to begin in 2021 with an investment of $4.5 billion over the next 5 years. The province of Ontario is a case in point, where

[1] The term "mental illness" is used because it reflects the language in CAMH documents. It should also be noted that although the term "people with mental health issues" may be viewed as more appropriate, "mental illness" and/or "mentally ill" still continues to be used across key mental health organizations, in government-speak and in academic journals. So, even though it may be more politically correct to say, "people with mental health issues," the reality is that "people with mental health issues" is "mental illness" by another name.

"mental illness accounts for about 10 per cent of the burden of disease . . . [but] it receives just seven per cent of health care dollars" (CAHM, 2023, para. 1). Relative to this burden, mental health care in Ontario is underfunded by $1.5 billion. This decline in mental health spending over time is attributed to, among various factors, the policy of deinstitutionalization.

Until recent decades, people experiencing mental health issues—then-termed as people with mental illness (PMI)—were receiving care in long-stay psychiatric hospitals operated by the state (Wood et al., 2011). However, the combination of pharmacological advancements and a shift in ideology toward community care and rehabilitation resulted in the release of PMIs from asylums into the community (Lamb & Bachrach, 2001; Perez et al., 2003; Wood et al., 2011). Unfortunately, the provision of community services has not been able to palliate the negative effects of cuts to public programs, which have resulted in more people with mental health and addictions issues residing in the community and believed to be in crisis. Increasingly, people in crisis (PIC), especially those with mental health issues, have become subject to frequent interactions with the police (Cotton & Coleman, 2014; Dempsey et al., 2020; Ghelani, 2022; Iacobucci, 2014; Kane et al., 2017). Police are often called to crises involving people with mental health and addictions issues through 911 dispatch because police are an emergency resource with a duty to respond to distress (Fahim et al., 2016). As such, the police have played a key role in the management of PIC in the community; police have become responsible for determining outcomes of interactions with PIC and often serve as gatekeepers in determining whether PIC who present with mental health issues will be processed through the criminal justice system (CJS) or the mental health system (Lamb et al., 2002; Lamb et al., 2004; Livingston et al., 2014; Patch & Arrigio, 1999).

Consequently, interactions between police and PIC have contributed to the criminalization of PIC and, at its extreme yet increasing, high-profile tragedies involving police shootings of PIC (Callender et al., 2021; Cotton & Coleman, 2014, 2016; Dempsey et al., 2020; Ghelani et al., 2022; Herrington, 2012; Mukherjee, 2022). To address this trend, police services in many jurisdictions have taken steps that they believe will better equip officers when responding to PIC. Reinforced by the view that police, alone, can no longer respond to mental health crises, police have enlisted interagency partnerships and collaboration with health and mental health systems and services by forming specialized mobile response teams (Butler, 2014). To date, various iterations of specialized CRTs, particularly those that involve police, continue to be widely implemented and supported in policy. These teams use myriad naming conventions, including CRT, (mobile) crisis intervention team (CIT/MCIT), mobile crisis response team (MCRT), and mobile crisis rapid response team (MCRRT), among others. In this dissertation, I have used the abbreviation most appropriate to the specifics of each study conducted and the related documentation.

Attention to police funding in mental health crisis response is particularly timely in two ways. First, recent movements such as Black Lives Matter in the United States and Canada have been vocal in their calls to divert police funding to community mental health resources and alternative models of crisis response. The prominent hashtag #defundthepolice has been used to draw attention to issues such as racism in policing and police violence, and to support public safety models that do not involve the police (Becken, 2023; Gollom, 2020). Second, despite evidence showing that it has been PIC who have been subject to police shootings in encounters with police—for example, "between 2000 and 2020, 68 per cent of people who died in

encounters with police in Canada were experiencing a mental health crisis" (Mukherjee, 2022, p. 141)—MCRTs involving police continue to be entrenched within policy.

This is the case for Ontario, where the government recently announced that it is expanding MCRTs, for which police will receive funding. In 2020, the Ontario government introduced the *Roadmap to Wellness: A Plan to Build Ontario's Mental Health and Addictions System* (Roadmap), updated in 2022 (Ministry of Health, 2022). Within this policy, the government indicated that it intends to address mental health and addiction challenges in the justice sector (Ministry of Health, 2022) by expanding MCRTs. Specifically, as of 2022, the government will be "investing more than $4 million over two years to expand Mobile Crisis Response Teams. Police services in 28 communities will receive grant funding to increase their capacity to respond to calls from individuals experiencing a mental health or addictions crisis" (Solicitor General, 2022, para. 1). The official justification for expanding MCRTs within mental health policy includes helping police assist people with mental issues, improve public safety, reduce interactions with police, and improve collaboration (Ministry of Health, 2022; Office of the Premier, 2020).

Overarching Aims, Rationale, and Approaches of the Dissertation

In this dissertation I explore the role of policy within CRT adoption. My research is not the first to attempt to understand prominence of CRTs and what it is about them that makes them an appealing initiative to adopt (see for example Study 1). However, the complexity of evidence on these teams warrants further scrutiny by adopting theoretical insights to interpret such evidence. I am also not the first to raise questions about the influence of police in mental health crisis response policy (see for example Boyd & Kerr, 2015). However, the three complementary approaches I use in in these studies, are an attempt to understand how problems come to be

known and understood, and how they are actualized in policy, provide alternative accounts of how police are and continue to be privileged across mental health spaces. Adopting alternative accounts of the policy process offers on the one hand a pragmatic insight about problem representation by drawing on the CIS methodology, frameworks of agenda setting (Kingdon, 2003) and policy choice (3i+E; Gauvin, 2014), and at the same time aims to problematize policy by adopting Bacchi's (2009) What's the problem represented to be? (WPR) framework.

The main goals of this dissertation are to advance understandings of policy and at the same time to disrupt traditional justifications for program development, moving toward a more critical understanding of MCRTs by uncovering the politics implicated within problem representations. My objective was to bring to light the social dynamics at play in the convergence of the disciplines of policing, health, and mental health and the nature of the processes of detection and management of PICs. I did so in three ways:

1. First, I developed a conceptual framework by completing an exhaustive review of literature on CRTs and using qualitative data analysis to situate CRTs across structural, system, and individual levels of development and implementation (see Chapter 2).[2]
2. Second, I documented the adoption of the MCRRT model (the origin of MCRT expansion in Ontario) in Hamilton, Ontario, from the perspectives of key decision-makers. The aim was to explore why key decision-makers from police, health, and mental health services came together to develop and implement MCRRT (see Chapter 3).

[2] For clarity, succinct presentation of findings, and legibility, particularly for the tables, we opted to follow Harvard style for Study 1 (Chapter 2). Study 1 references and citations therefore also follow Harvard style, whereas Studies 2 and 3, and the remainder of this dissertation, follow the style of the American Psychological Association.

3. Third, I critically examined official government discourse pertaining to expansion of MCRTs, the assumptions embedded within it, and its effects. My intent was to engage in disrupting these official accounts through alternative discourses (see Chapter 4).

Chapter 2 presents Study 1, a critical interpretative synthesis (CIS) of available literature pertaining to the conditions under which CRTs are developed and implemented and their features. It draws on multiple sources of evidence to construct a framework based on the interpretation of evidence to bring new insights about CRT processes. It has been unclear why CRTs continue to be implemented, particularly against the backdrop of calls for alternatives to police response to mental health. As such, the intention was to understand the plethora of evidence about CRTs from a policy perspective. To accomplish this task, and what differentiates this study from other representations of evidence, I applied a policy lens to interpret existing evidence. Kingdon's (2003) agenda setting framework, which explains how issues come to the attention of decision-makers and how governments set agendas, and the 3i+E framework (Gauvin, 2014), which describes why policy choices are made, were used to map and interpret data. Additionally, to organize the data, I used a well-established health and social system arrangements taxonomy of governance, financial, and delivery arrangements and implementation strategies within health systems. The enriched understanding from the framework developed from this approach creates space to better understand and explore relationships between structure, systems, and individuals that produce a continued reliance on CRTs.

In Chapter 3, Study 2, I build on existing knowledge about CRTs derived from the CIS, including its findings that CRTs are largely concentrated at the system level. In other words, decision-makers attribute structural conditions (e.g., decentralization, deinstitutionalization) as

the reason behind CRT inception, yet CRTs do not appear to address these structural conditions. Furthermore, the extent to which they address individual-level considerations is questionable, yet at the systems level, they appear to be growing in magnitude. Study 2 aims to understand this phenomenon by asking why CRTs are adopted as a policy choice.

At the time of designing this study, I obtained extensive access to high-level decision-makers within police and health systems in Hamilton, Ontario, where a first-of-its-kind CRT was developed and implemented, the MCRRT model. I obtained open access to observe MCRRT presentations and training, and it became apparent that the model had been developed and endorsed by high-level decision-makers. To explore this development more fully, I used a qualitative explanatory single-case study approach to examine how and why MCRRT was implemented in Hamilton, Ontario. To gain insight into the policy process, I applied a policy lens to the data analysis, guided by the agenda setting (Kingdon, 2003) and 3i+E (Gauvin, 2014) theoretical frameworks.

Chapter 4, Study 3, remains consistent with the intent to study CRTs from a policy perspective but takes a post-structural approach to engage in a critical interrogation of responses to policy "problems." Specifically, this chapter departs from an understanding of MCRT as a policy response to a problem, to one where MCRTs are responding to particular types of problems. (I use the term MCRT in Study 3 as that is the term used in the policies I reviewed). Drawing on the WPR approach, I aim to disrupt common assumptions about the government's role in solving problems (Bacchi & Goodwin, 2018). One assumption is that problems exist "out there" and have an objective and independent existence waiting to be defined and for which a solution can be developed. Instead of beginning from this assumption, Bacchi (2009) began with the premise that rather than reacting to problems, governments are active in producing particular

types of problems and these are constituted through policy. Policies then are inherently problematizing activities; "we are governed through problematisations, rather than through policies" (Bacchi, 2009). Concerned with "what policy makers *really* meant to do" (Markauskaite & Freebody, 2011, p. 172; emphasis in original), the purpose of WPR is to "ascertain representations of the truth, rather than the 'truth'" (p. 172).

This is not to say that the previous chapters are uncritical—the CIS was produced through the interpretation of evidence that offers new insights for understanding the phenomenon while maintaining a critical voice (Dixon-Woods, 2016), and findings from Study 2 point to the role of dominant structural interests that uphold the legitimacy of dominant institutions. Chapter 4 attempts to fill this gap by taking up unproblematized concepts and practices for further inquiry.

Anticipated Contributions

I anticipate that this doctoral dissertation will make theoretical, methodological, and substantive contributions to discourse about CRT policy. Theoretical contributions to discourse about CRTs pertain broadly to various policy analysis approaches used to make sense of this phenomenon. First, in the CIS (Chapter 2), the use of agenda setting and 3i+E policy frameworks (Kingdon, 2003; Gauvin, 2014), coupled with the use of social system arrangements taxonomy to map, organize, and interpret data, produced a new conceptual framework. This framework explains the connections between structural, system, and individual factors related to the conditions under which CRTs are formed, their features, and their outcomes. My hope is that this framework will draw attention to the positionality of CRTs as an intermediary between the conditions that give rise to them in the first place and the individuals for whom they are ostensibly deployed. Furthermore, using the conceptual framework as a guide, I hope to draw the

attention of decision-makers, practitioners, and scholars to challenge policy considerations that reproduce these teams. In Study 2 (Chapter 3), findings from the case study provide theoretical insights about how key decision-makers understand and define the problems to which CRTs respond. Moreover, findings in this study indicate how and why the MCRRT was prioritized for decision and why it took the form that it did. Last, by using the WPR approach (Bacchi, 2009), Study 3 (Chapter 4) provides new ways of thinking about policy problems to which CRTs are the proposed solution. Specifically, this study contributes to broader critical policy studies that aim to make visible the politics in which CRT is implicated; that is, the "*heterogenous strategic relations and practices* that shape who we are and how we live" (Bacchi & Goodwin, 2016, p. 14, emphasis in original).

This dissertation also makes methodological contributions to the study of CRTs. We drew on existing methods, and it is the unique mix of approaches across the three studies that enable me to interrogate a policy issue from various angles. The findings from each methodological approach both complements and/or challenge findings in the studies. For example, the CIS shows that structural conditions shape the type of policy choices that are made at the systems level which, which I confirmed through the case study approach. In the third study, by drawing on the critical policy analysis, I excavate how CRT policy plays out in practice which demonstrates how policies are structured (in a Foucauldian sense) and ways that these structures can be resisted. The utility of these three methodological and theoretical approaches provides insight into the pragmatics of policymaking and at the same opens opportunities to disrupt them.

Importantly, the use these established yet distinct approaches to policy studies allows for an in-depth analysis and interrogation of CRTs. Doing so challenges the researcher with never sitting too comfortably within a specific approach. Rather, I remain curious about how

knowledge production occurs and how it manifests through policy. Incorporating various approaches to understanding policy engages in what Mills (1959) called the sociological imagination, where one must 'make the familiar strange and the strange familiar'.

Finally, I anticipate that substantive contributions from this dissertation will significantly contribute to scholarly studies in several areas. Two examples are criminal justice policy using agenda setting in examining the conditions under which policies adopted, and critical policy studies relating to how people are governed. In terms of pragmatic considerations, the CIS offers substantive insights into key elements of CRTs when understood as governance, financial, and delivery arrangements and implementation strategies. It may be particularly influential for CRT program design and evaluation.

The Study *of* CRTs or *for* CRTs and Back Again: Situating the Researcher

My decision to undertake the study of CRTs was not in absence of a relationship with the subject matter. Rather, it reflected the various roles that have influenced my development as an academic, a critical scholar, and a former mental health practitioner. These roles and influences have sat in contention with one another as I completed this dissertation, which is as pragmatic as it is a critique. I have struggled at various times during the research to reconcile the dichotomy, creating opportunities to reflect on my positionality in ways that go beyond awareness and disclosure to include how these positions shape research. For over a decade I worked in various areas of mental health services, including mental health crisis response, primarily with mental health and secondarily with police. My work occurred in tandem with the pursuit of academia, where I was challenged to think about practice from a critical lens and where I first found myself in contention between practice and critique of practice. On the one hand, like many in the helping professions, I am committed to anti-oppressive practice. On the other hand, as a frontline

worker, I could not ignore that most of my time was spent on completing risk assessments, filling out electronic records, or simply patching up a PIC only to refer them to other agencies. The termination of my mental health practitioner role rested on one question I found myself repeatedly asking: "How do I CBT[3] a person out of homelessness?"

Around the time I exited my practitioner role, I noticed that government programs and initiatives were moving toward crisis response models. This trend was timely for me as I was accepted into the doctoral program. Through my contacts in the field, I was connected with government officials and gained exceptional access to projects and people developing the MCRRT, which I was determined to study as part of my research because I believed that my practical experience and my critical edge would contribute to improving conditions for PIC. I was transparent about my pragmatic and critical endeavours for my dissertation, and both were welcomed. During my access, I was asked to provide insight into the phenomenon and eventually contributed my "expertise" to the framework and design of a memorandum of understanding—neither were used in my dissertation. The significance of such access became a mix of joy and terror: joy because I was in effect a nobody among high-ranking officials, and also a person with lived experience of trauma (which I hid well – what Goffman refers to as 'passing' in relation to stigma), influencing policy, and terror because I could not unsee that enmeshed within this policy are new modes of governing individuals. I found myself asking yet another question: "Is my dissertation the study *of* CRTs, or is my dissertation *for* CRTs?" The difference is subtle but the ramifications were real because it raised questions about who I am, who I am going to be as a scholar, and for whom my scholarly research would be produced.

[3] CBT refers to cognitive behavioural therapy, which was commonly used as the go-to approach for managing mental health symptoms, behaviour, and crisis.

I decided to take up these contentions through various approaches of policy analysis, which subsequently make up the three studies in this dissertation. My aim was not to resolve the contentions between policy of and policy for; rather, in taking up the topic of CRTs, my hope is that this dissertation comes to be viewed as a project of reflexivity, one that is anchored in the various theoretical and methodological approaches it has drawn upon, the conclusions it presents, the questions it raises, and the disruptions it hopes to make.

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Chapter 2: Study 1

Preface

This chapter provides a synthesis on the conditions under which police, health, and mental health crisis response teams (CRTs) are formed, their features and their outcomes. A review of literature of CRTs was completed according to methodology of a critical interpretative synthesis. A conceptual framework was developed where CRTs are located within structural, system, and individual levels of development, including variables specific to the system level in which CRTs are concentrated, such as features and outcomes. I was responsible for structuring the research question and study design, completing data collection and analysis and generating the conceptual framework. A graduate student was the second reviewer in assessing the eligibility of 20% of the initial titles and abstracts and 20% of full-text documents. Dr. Michael G. Wilson contributed to the study design and methods, data synthesis and analysis as well as the construction of the conceptual framework and ongoing feedback to the chapter as it was drafted. Dr. Julia Abelson and Dr. Lauren Eisler guided the construction of the conceptual framework and ongoing feedback to the chapter as it was drafted.

A Critical Interpretative Synthesis of Police, Health, and Mental Health Crisis Response Teams

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Keywords: crisis response teams, CRTs, police, health and mental health crisis response, critical interpretive synthesis, CIS, people in crisis, PIC, policy development and implementation, system arrangements

Word count: 5,901 (main text) 11,114 including tables and figures
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Abstract

Introduction: In recent decades, people in crisis (PIC), especially those with mental health issues, have experienced frequent interactions with the police. Police services have taken steps to better equip officers when responding to PIC, such as establishing partnerships between the police service, health, and social systems by forming specialized crisis response teams (CRTs). **Methods**: A critical interpretive synthesis (CIS) was used to address the compass question: What are the conditions under which CRTs that include police, healthcare providers, and mental health professionals are formed, what are their features, and what are their outcomes? Sixteen health and nonhealth databases were searched to obtain empirical and nonempirical documents. Eligible documents were conceptually mapped according to relevance, components of the compass question, and core components of existing conceptual frameworks. Using this scoping exercise, we derived a purposive sample of information-rich documents for in-depth qualitative analysis and synthesis to develop and iteratively refine a conceptual framework. **Results**: Searches yielded 18,110 results from which 80 were deemed eligible for inclusion with 50 prioritized for a purposive sample of information-rich documents. Conditions under which CRTs are formed occur at structural, systems, and individual levels. Unresolved structural conditions produce systems and individual level challenges contributing to forming CRTs. Features of CRTs reflect system and policy goals related to addressing PIC. Because CRTs do not address overarching structural barriers, their effectiveness on outcomes have been found to be at best mixed. Despite mixed evidence, CRTs are difficult to refine or replace with models that may generate better outcomes due to structural barriers that limit such large-scale reform. **Discussion**: Our framework presents a broader view of the process of incremental decision-making whereby police, health, and mental health systems adapt by entering into partnerships out of shared

interest in addressing problems pertaining to PIC. These adaptations and policy legacies make it challenging to consider alternatives, especially in the absence of a commitment to learning and improvement cycles aiming to change features of such models over time to optimize outcomes based on data and evidence.

Introduction

In their daily functions, police officers encounter various situations and interactions with the public that do not require law enforcement in the traditional sense, but rather involve de-escalation of conflict, conflict resolution, and mediation (1). In recent decades, people in crisis (PIC), especially those with mental health issues, have become subject to frequent interactions with the police (1, 2). Commonly cited factors contributing to this phenomenon include cuts to long-term psychiatric facilities and changes in treatment models, including a focus on provision of services in the community. Unfortunately, the provision of community services has not been able to palliate the negative effects of cuts to public programs, which have resulted in more people with mental health and addictions issues residing in the community (3-5). As such, the police have increasingly played a key role in the management of PIC (6-8). The police are often called to crises involving people with mental health and addictions issues through 911 dispatch because police are an "accessible emergency resource and have a legal obligation to respond to distress calls" (9 p. 929).

As a result, the police become responsible for determining the outcome of the interaction, which may include recognizing the need for treatment, connecting these individuals to appropriate community services and resources, apprehending the individual, and/or transporting them to the hospital for further assessment and intervention. If illegal circumstances are present, police are then tasked with arresting the individual on the basis that illegal activity takes precedence over other considerations (3, 4). As such, the police often serve as gatekeepers in determining whether PIC who present with mental health issues will be processed through the criminal justice system (CJS) or the mental health system (6, 7, 10, 11). This role has resulted in labels for police officers such as "psychiatrists in blue/street-corner psychiatrists" (7) or "de

facto mental health workers" (11). Moreover, even though police have a long-standing history of responding to calls involving people with mental health issues or those at risk for suicide, evidence suggests that these situations are on the rise. As such, police continue to be de facto responders to mental health concerns in the community (8).

To address this trend, police services in many jurisdictions have taken steps to better equip officers when responding to PIC, including provision of mental health training and crisis intervention skills. Mental health training for officers is viewed by both police services and mental health systems as an opportunity for officers to gain a broader understanding of PIC and experiences they may have, create awareness of mental health issues (with hope of reducing stigma), and better prepare officers to respond to these calls. Other initiatives have included establishing partnerships between the police service, health, and social systems by forming specialized mobile response teams (6, 12). Various programs of specialized response to PIC can be loosely organized into three categories (13): police-based specialized response, police-based mental health response, and mental health–based specialized response. These programs adhere to two mainstream models: the crisis intervention team (CIT) model (police-based specialized response) or the co-response model (combined police, health, and mental health response). Several studies have reviewed, summarized, and mapped the various components of these response models (14-18). However, to date, no framework has been provided to connect these components in relation to outcomes and the mechanisms that underpin the development of those outcomes. Based on a review of the literature on police, health, and mental health system response models, this paper presents a conceptual framework that outlines (a) the factors contributing to the development and implementation of such models, (b) features of these models, and (c) their outcomes.

Methods

Design

This study used the critical interpretive synthesis (CIS) methodology, which draws on a diverse body of literature to generate a theory or conceptual framework (19). Current research on police, health, and mental health crisis response models is large and complex stemming from the variations implemented across different jurisdictions (e.g., first or secondary response, co-response, partnership, collaboration) and how they are studied (e.g., qualitative and quantitative methods, cross-disciplinary approaches, theoretical and nontheoretical work). For simplicity, in this paper we refer to all police, health, and mental health crisis response teams as CRT. The CIS method focuses on developing theoretical constructs based on the available evidence, which become subject to further scrutiny through an in-depth review and synthesis process that draws on evidence synthesis and qualitative methods (19). As such, it requires reflexivity, rejecting the use of a fixed approach and predefined categories to summarize the findings and calling instead for a more iterative and interactive approach (19). The CIS approach uses a compass question. In contrast to conventional evidence syntheses that require a precise research question, CIS acknowledges the "tentative, fuzzy and contested" (19) nature of the research process and allows the question to be iteratively refined and to act as a guide for the key conceptual areas of inquiry of interest. We began the CIS with an initial scoping exercise to identify potentially relevant literature and organize it using existing theoretical constructs. After this initial survey, the following compass question guided our CIS: What are the conditions under which CRTs that include police, healthcare providers, and mental health professionals are formed, what are their features, and what are their outcomes?

Literature search

Given that relevant literature was likely to be found indexed across many different databases, we developed a search strategy in consultation with two librarians with expertise in health and social sciences databases. The following 16 health and nonhealth databases were searched: Embase, PhyschInfo, MedLine, CINAHL, Criminal Justice Abstracts, Humanities & Social Sciences Index Retrospective: 1907–1984 (H. W. Wilson), Social Sciences Index Retrospective: 1907–1983 (H. W. Wilson), Social Work Abstracts, Canadian Research Index, Dissertations & Theses, EconLit, International Bibliography of the Social Sciences (IBSS), Politics Collection, ProQuest Dissertations & Theses Global, Sociology Collection, Ingenta Connect. The search strategies were customized for each database but included combinations of terms related to policy and law enforcement, mental health, and addictions and crisis response and were last run in January 2023. The detailed search strategies are included in Appendix A, Tables A1 and A2. We reviewed the reference lists of all included documents to identify any potential additional articles. We found that most sources referenced one another, which helped us to determine that saturation had been reached. Due to resource and time constraints, only documents written in English were included.

These documents were then assessed in full according to the inclusion and exclusion criteria. The inclusion criteria were CRT models for PIC, who were broadly defined as people experiencing mental health challenges. Models where the police officer was the only individual responsible for determining the outcome of the interaction were excluded. Documents were also excluded where a model of response addressed specific populations such as veterans or children and youth, or populations that required a specialized service such as mobile safe injection response teams.

To ensure the inclusion and exclusion criteria were consistently applied and a reliable sample was generated, a second reviewer independently assessed a random generation of 20% of the initial titles and abstracts and then independently reviewed another random generation of 20% of the selected full-text documents. Any discrepancies in coding were mutually discussed to reach consensus. Inter-rater reliability was assessed through a Kappa statistic calculated to be 0.725 for the initial title and abstract review and 1.0 for the full-text review. In the full-text review of the revised electronic search in 2023, AT sought assistance from MGW if unsure whether to include or exclude any documents.

Conceptual mapping of relevant documents

The full texts of all potentially relevant articles were assessed to identify conceptually rich areas and gaps in the research, build a data extraction tool, and inform the selection of a purposive sample of relevant papers for analysis. AT completed the mapping exercise, placing an X whenever a concept pertaining to a compass question domain (conditions under which CRTs are formed, their features, and their outcomes) was present, and then tailoring the domains to the literature by generating themes specific to each one.

For conditions under which CRTs are formed, we used two existing political science frameworks: Kingdon's agenda setting framework (20), which explains how issues come to the attention of decision-makers and governments set agendas, and the 3i+E framework, which describes why policy choices are made (21). For features and outcomes, we derived a set of categories based on increasing familiarity with the literature and then coded all included articles with the refined framework, organized according to a pre-existing and well-established health and social system arrangements taxonomy of governance, financial, and delivery arrangements and implementation strategies within health systems (20).

Kingdon's agenda setting framework focuses on how issues initially get attention by decision-makers (which is referred to as the governmental agenda in the framework) through three streams of influence: problems, policies, and politics (20), with problem and politics driving initial attention to an issue. In the problem stream, conditions come to be defined as problems for which action needs to be taken through focusing events, changes in relevant indicators and/or feedback generated from the operation of existing policies or programs. Political factors such as elections or changes in political party, public opinion and interest groups can influence attention given to an issue by decision-makers. Issues are then prioritized for active decision when there is a compelling problem, conducive politics and potentially viable policies, Policies are generated through diffusion of ideas over time, feedback from the operation of existing policies or programs that reveal potential solutions to problems that have emerged and through communication and persuasion (often from highly visible policy actors that use their visibility to advance ideas). These streams operate independently of one another until a window of opportunity opens through which all three streams combine to bring elevate an issue to being up for active decision.

The 3i+E framework is useful tool for exploring how institutions, interests, and ideas (the 3i's), and sometimes external factors (the E), influence policy choices that are made to address prioritized issues (21). Institutions refer to the "rules of the game"—the formal and informal rules that shape political behaviour—including government structures (the political arrangements of countries, mandates and mechanisms that foster accountability between government and agencies), policy networks (actors outside of the formal government process that influence policy development and choices), and policy legacies (past policy decisions that, once put in place, are difficult to reverse, also referred to as path dependence). Interests refer to actors who

benefit from or bear the costs of policy decisions. Ideas in policy development consist of thinking about "what is" (e.g., the state of circumstances involving PIC) and "what ought to be" (what needs to be done). Finally, external factors include major reports, high profile cases, and court decisions.

Lastly, we used a taxonomy of health and social-system governance (i.e., who gets to make what decisions), financial (i.e., how money flows to and through the system) and delivery arrangements (i.e., how care and services are designed to meet client needs, human resources, and infrastructure) (20) to conceptually map potential features that CRTs could adopt, which was then used to develop more nuanced understandings of potential features adopted and in what contexts. We also included potential features of implementation strategies such as education offered to consumers, providers, and/or organizations (22-24).

Data extraction and analysis

Results from the conceptual mapping process were used to purposively sample the richest documents in relation to the three domains of interest. A data extraction tool was developed during the mapping exercise and refined as new codes and themes were identified. The codes and selected articles were organized and imported into NVivo software, and line-by-line coding was used to extract and analyze information. The coded data were further analyzed using the constant comparative method (19, 25) to generate themes related to the core areas of interest in the compass question to generate a theoretical framework.

To determine the number of articles to include in the purposive sample, we decided that it should include all existing evidence syntheses (i.e., documents that had already systematically and transparently identified and synthesized evidence about topics related to CRTs), as they were

likely to capture the breadth of the literature. We then prioritized including additional documents that were deemed to be conceptually rich across each of the compass question domains.

Results

Document selection

Our database searches yielded 18,110 results, of which 80 were deemed eligible for inclusion and 50 were purposively sampled (see Appendix A, Figure A1). Initial searches generated 17,079 results (*n* = 11,548 for health sciences and *n* = 5,531 for social sciences). After removing duplicates (*n* = 8,959) and documents older than 10 years (*n* = 3,155), AT carried out an initial eligibility screening of the title and abstract of each document (*n* = 4,965), excluding all but 125. A second search in January 2023 yielded an additional 1,031 documents. After removing duplicates and screening titles and abstracts, all but 20 were excluded.

Details of the included documents are provided in Appendix B, Table B1. From the 58 documents reporting primary research, seven were systematic reviews, one was a scoping review, 22 were qualitative studies, four were quantitative, 10 used a mixed methods approach, and six were classified as evaluations. The most common types of non-empirical papers were commentaries and discussion papers; one was described by the authors as a policy article review. Table B2 presents an overview of the conceptual mapping of the included 80 documents in relation to the compass question domains. Our purposive sample of 50 conceptually rich documents was derived from this mapping to generate the framework, which is presented below, followed by an overview of key findings in relation to each of the compass question domains that integrated to iteratively develop and refine the framework.

Overview of conceptual framework components

The framework we derived (presented in Appendix C, Figure C1) provides a way of conceptually understanding the interconnections between the conditions under which CRTs are formed, the menu of possible features that can be combined to form CRTs, and outcomes of relevance used to evaluate them. Conditions under which CRTs are formed occur at the structural, systems, and individual levels.

We identified decentralization of governance and deinstitutionalization as overarching, unresolved structural conditions that produce challenges at the systems level and impacts on individuals. At the systems level, challenges include a lack of mental health system supports, lack of funding, lack of police training, criminalization of mental health conditions, increased interaction between police and PIC, and poor system coordination. For individuals, the major impacts include increases in the number of PIC in the community, overuse of the emergency department (ED), and increased interactions with police. These challenges and impacts shape the conditions for CRTs being formed. Police, health, and mental health services have engaged in partnership, collaboration, and coordination at the systems level to form CRTs. Features of CRTs have been developed to address key system and policy goals related to addressing the needs of PIC, reducing police and PIC presence in emergency departments, ensuring cost-effective delivery, and reducing apprehensions. Given these goals, features vary based on how systems have adapted to structural conditions, systems challenges, and impact on individuals, including a partnership history; existing senior management support; existence of centralized, no-refusal drop-off facilities; ability to provide 24/7 availability; and provision of or commitment to additional police training in mental health.

However, because the system responses do not address overarching structural issues, the effectiveness of CRTs on outcomes related to population level (e.g., diversion from CJS and ED), service level (e.g., effectiveness and efficiency), client, community, and provider experience are at best mixed; these outcomes are depicted using arrows to show increase, decrease and the tilde symbol to demonstrate mixed results. Despite this mixed evidence, structural barriers that constrain large-scale reforms for how to respond to and support PIC are difficult to implement or replaced with alternative models that may have the potential to generate better outcomes.

The broken line arrows from structure to outcomes and from individuals to outcomes demonstrate potential alternative pathways of influencing outcomes. Figure C1 depicts the greatest load for addressing structural issues, challenges, and impacts as occurring at the systems level. Here, variations of CRTs are concentrated and undergo adaptations without substantial impact on either structural conditions (depicted by the solid line moving from CRTs to structural), challenges at the systems level (depicted by the broken line moving from CRTs to systems), or their impacts on individuals (depicted by the broken line from CRTs to individuals). However, if structure, systems, and individuals are considered to interact with one another, then changes that impact the structures and individuals, by considering alternatives to CRT responses, may have the potential to generate better outcomes.

Specific insights about conditions under which CRTs are formed

Our CIS shows that several factors contribute to the formation of CRTs (see Appendix C, Table C1), which are driven by structural conditions, and which result in challenges at the systems level and impacts at the individual level.

Agenda setting factors

Agenda setting factors contributing to the problem definition include the increase of PIC in the community postdeinstitutionalization, police as primary mental health responders, criminalization of mental health conditions, and overuse of the ED. With lack of community services to meet the demand for mental health care, PIC are often presenting in the ED or come to the attention of police (3, 14, 26-31). Police have become de facto mental health responders stemming from their first-responder role. Police are often ill-equipped to effectively respond to these situations, which consume a substantial amount of officer time. Criminalization of mental health issues has also been recognized as a problem: officers who are not trained in mental health respond by arresting these individuals, as arrest may be the only pathway to obtain care. Neither public health nor law enforcement is equipped to provide the needed level of care for PIC presenting with a mental health concern, even though both have become the de facto emergency response system for these individuals (32-36).

Decision-makers are likely to consider a policy option when it aligns with their perspectives. A key theme pertaining to the policy stream is the framing of CRT response as an alternative response to address PIC. It stems from a recognition that police cannot address mental health crises alone and EDs are overburdened. Thus, CRTs were established as an alternative intervention aimed at diversion—from the CJS and from the ED—while also providing immediate links to mental health services (5, 27, 29, 37). These policy alternatives align with strained resources due to the pooling of expertise, systems, and information. As well, in the face of criminalization of PIC, coupled with poor outcomes of interactions between police and PIC, these teams offer a more appropriate form of referral and intervention.

In the political stream, the main theme that influenced the forming of these teams was public outrage over police-involved deaths of PIC. Swings in national mood are a key driver of pressure on governments to address an issue. In the case of CRTs, public outrage over these tragedies put pressure on governments to provide alternative access to crisis services by partnering police officers with mental health clinicians (3, 29-31, 35, 38-42).

Political system factors (3i+E)

We identified three main findings in our analysis of political system factors (see Appendix C, Table C1). First, within institutions, CRTs have generally emerged as a policy of choice because of strong policy legacies—decentralization of governance and deinstitutionalization—that have invested in capacity for the groups who typically lead CRTs (primarily police and also healthcare). In addition, CRTs are designed to be community led, which enables CRTs to be a desirable option in the context of decentralization (41, 42). Additionally, policy legacies appointing police and health care to be the focal point for responding to PIC (such as mental health legislation, which grants police the power to apprehend PIC for transport, treatment, and/or hospitalization), reaffirm the central role of these systems. Pursuing a dramatically different approach would be hard to achieve without significant investment and reallocation of resources within any given system. Without political will for such a dramatic change in dominant systems of delivery, models that prioritize these groups at the centre of responses are the most viable policy options.

Second, powerful interest groups play an important role in influencing policy decisions. Interests that have a concentrated benefit and diffused costs for groups are more likely to be implemented (21). CRTs are largely police driven and incorporate already-existing infrastructures (policing and health care) while incorporating incremental pathways for diversion

such as incorporating mental health professionals within their teams (5, 16, 18, 27, 30, 37, 43-47). Any dramatic shift in resources would ultimately be met with resistance from these well-resourced groups. Therefore, the incentive is for those groups to support policy alternatives that involve a change in how the challenge is approached, but with them continuing to play a central and well-resourced role.

Third, the main themes that pertain to ideas include the shifting of values toward providing care in the community, by appropriate people, such as the presence of a mental health professional to improve experiences for PIC (5, 32, 42, 48, 49). Additionally, movement toward decriminalizing mental illness and reducing the stigma of mental illness when interacting with police add to the appeal of CRTs because it shifts the nature of interactions from apprehension to addressing mental health. Evidence pertaining to high rates of criminalization and negative interactions between police and PIC places pressure on police services to shift how they respond to PIC. Incorporating health and mental health partnerships through addition of a mental health professional, and coordinating services of care, increases consideration of CRTs as a viable solution.

Fourth, major reports consistently underscore models that adopt partnerships in the form of CRT-based models, further elevating CRT as a viable alternative. Specific recommendations are for police to establish partnerships with mental health agencies (27, 29, 38, 41, 50).

Features of CRTs

We organized our analysis of features of CRTs using established social and health system arrangement taxonomies described in the methods section. Our analysis presents findings according to the system arrangement taxonomies, including barriers and facilitators to implementation and an overview of key elements discussed in the literature (see Appendix D).

Within governance arrangements, decentralization plays an important role in facilitating collaborative approaches that reflect the unique needs of a community (27, 41, 42). Key features include management approaches that foster senior and executive leadership support for CRTs (18, 49, 51). Equally, networks consisting of multi-institutional arrangements through partnership and collaboration between police, health service providers, and mental health services, including a history of collaboration, are a key element to implementing CRTs (17, 27, 30, 31, 33, 37, 45, 46, 49, 50, 52-55). A major challenge within governance arrangements is the actual coordination across various systems; specifically, clarity is required regarding procedures, roles and responsibilities, and accountability mechanisms to ensure that CRTs operate as an organized and coordinated system (17, 27, 30, 31, 33, 37, 45, 46, 49, 50, 52-55).

Within financial arrangements, the literature points to a lack of clarity regarding funding of CRTs (including the entire financing structure) and financial arrangements between collaborative services. Typically, CRTs draw on multiple and mixed funding sources (27, 28, 31, 34, 46, 49, 53, 56, 57). Delivery arrangements that are key to success of CRTs include: (a) availability of care; that is, to expand availability of CRTs to 24 hrs (18, 29, 31, 34, 35, 38, 40, 42, 46, 49, 52, 55, 58); (b) system—need, demand, and supply; there is a need for partnership and collaboration across systems, specialized training for police, and mental health professionals to support police in responding to the increase in interactions between police and PIC (17, 18, 29, 31, 34, 35, 37, 38, 40, 42, 46, 49, 52, 55, 58); and (c) multidisciplinary teams consisting of collaborative partnerships between police, health providers, and mental health professionals that tailor CRTs at local and regional levels (5, 17, 18, 29, 31, 34, 35, 37, 38, 40, 42, 46, 49, 52, 55, 58).

Findings show a limited understanding of the essential elements and processes for CRTs; however, across the literature, key themes pertaining to essential components largely pertained to how these partnerships are organized (see Appendix D, Table D3). Essential elements for implementation of CRTs include collaborative planning and implementation, co-location, specialized drop-off centres, coordination including staffing, long-standing history of partnering among services, information-sharing, ongoing feedback, senior management support, personnel competencies and characteristics, and training and evaluation (18, 37, 49, 51).

Outcomes of CRTs

Findings from the CIS pertaining to outcomes are consistent with previous evidence of mixed results (see Appendix E). Findings indicate that outcomes measuring perception are more favourable measures of CRTs than objective evaluations. We organized our findings according to population level, service level, client perception, community and stakeholder perception, and provider perception outcomes (see also Figure C1).

Population level outcomes: The main findings pertain to policy development and implementation stemming from the problem of PIC in increasing contacts with police, overuse of EDs and criminalization, and the need to divert these individuals from the ED and the CJS. Although most contacts were responded to in the community and use of community referrals was high, results for diversion rates were mixed (4, 5, 14, 17, 18, 30, 40, 45, 46, 53, 59, 60). ED escorts following a CRT intervention were more likely to be voluntary, and where diversion from ED was successful, hours saved for responders and ED staff (i.e., time spent on a PIC call) was substantial (5, 9, 17, 18, 30, 34, 44, 45, 49, 51, 57-59). Even so, the remainder of evidence was mixed that CRTs reduce hospitalizations (5, 9, 17, 18, 30, 34, 44, 45, 49, 51, 57-59). Similarly, although apprehension under the Mental Health Act (MHA), also referred to as Mental

Health Legislation, decreased, little evidence was found that CRTs reduce criminalization. A 2018 review of studies could state only that crisis response models might reduce, not would reduce, use of policy custody and apprehension (14).

Service level outcomes (i.e., efficiency and effectiveness): Efficiency, measured by factors such as time spent responding to a call, duration on scene, and timely assessment, showed positive outcomes of CRTs. Particularly, findings indicate that CRTs contribute to time savings for both police and ED staff when transporting PIC to the ED. Where response times were higher, this was attributed to increased use of the CRTs. CRTs were mainly efficient in freeing up other police officers to attend to other duties while the team addressed the mental health–related issues. There was also an increase in referrals and linking PIC with community resources. Findings show that CRTs reduce costs compared to standard service provision. Reduced costs are associated a decline in use of MHA apprehensions/detentions, thereby reducing ED psychiatric hospitalization (5, 17, 18, 40, 44, 53).

Client perception: Findings show that generally PIC had positive experiences with CRT models. Particularly, service users described the ability of the mental health worker to de-escalate crisis while using empathy, effective communication, compassion, and mental health knowledge and resolving the crisis in their own environment (5, 17, 18, 33, 37, 45, 51, 54). PIC experiences with CRTs were strongest when discussing their interaction with the mental health practitioner and when police were less visible, including use of an unmarked vehicle and plainclothes officers.

Community and stakeholder perception: Findings indicate a general support for collaboration between police and mental health professionals, and that CRTs are a valuable

resource to meeting the needs of PIC (18, 37, 51, 53). Stakeholders also indicate that CRTs should be first responders instead of a secondary response model (18, 37, 51, 53).

Provider perception: The experiences of police officers who are part of a CRT showed a positive perception of the model. Particularly, the knowledge gained through specialized mental health training, and the clinical expertise of mental health clinicians, aided in addressing the crisis without use of MHA while shifting their perspectives and attitudes toward mental health challenges and PIC; they felt more prepared to handle PIC (18, 43, 49, 54, 59). Access to relevant information was considered vital to making decisions about PIC, which increased their confidence when making decisions about risk and courses of action. Results also show that CRTs improve partnership, collaboration, and coordination between police, health, and mental health services, which in turn improve speed and clarity of pathways to treatment for PIC. Partnership and collaboration improved communication, knowledge, and understanding of roles and responsibilities of CRT members. Mental health professionals reported feeling safer when attending calls alongside police officers and engaging in shared decision-making, which improved systems pathways for PIC. A major recommendation from the perspective of practitioners is that more resources were needed to meet the demand of PIC calls for services, including additional hours of operation, secured funding for clinicians, and resources by way of centralized drop-off services and mental health services for PIC (17, 18, 34, 45, 56, 59).

Discussion

Our framework offers a comprehensive understanding of the adaptative processes undergone by police, health and mental health systems over time to establish CRTs. These adaptations are responses to unresolved structural conditions that create system level challenges and their impacts on individuals. CRTs have evolved through collaborative partnerships between

police and health systems, driven by a shared interest in addressing pressing problems pertaining to PIC. It also highlights how adaptations at the systems level, combined with persistent and challenging-to-alter policy legacies, pose obstacles to exploring alternative approaches. CRTs are predominantly concentrated at the systems level, leading to adaptations with varied outcomes, creating uncertainty about their overall impact. We posit that without evidence-based assessments of CRT outcomes and a clear framework for learning and improvement cycles guided by data, evidence, and feedback to optimize model features and outcomes, CRTs may undergo adaptations that result in minimal impact on structural, systemic, and individual levels.

Our framework shows that CRTs do not address the structural conditions that contributed to the challenges faced at the systems level and impacts at the individual level. Moreover, we do not yet know whether CRTs actually address the impacts on individuals (PIC). A key issue identified in our CIS, and which stems from the policy legacy (structure) of deinstitutionalization, pertains to the criminalization of people with mental illness. Studies in our CIS do not raise questions about role of structure, for example, structural stigma[4], in perpetuating criminalization of mental illness and instead accepts criminalization of mental illness as a type of 'fact' or unintended consequence. If the issues stem from structural conditions, then those key structural issues should be addressed including the consideration of risk and danger discourses and assumptions about people with mental illness that subject them to arrest by police. We are not suggesting a return to institutionalization of people with mental health issues; instead, our CIS suggests that potential pathways of influence that stem from structure and individuals, in combination with systems, may produce better outcomes. In other words, we are saying that structure, system, and individuals interact with one another, and as a result, alternatives must be

[4] See Hannem, 2012 for definition and application of structural stigma; also study 3 in this thesis.

considered in each so that meaningful change occurs. These alternatives must consider the inequitable social context that perpetuates people with mental illness experiencing crisis for which there are fewer avenues for help making police as the de-facto responders to mental health circumstances.

Lastly, our framework depicts the process of incremental decision-making whereby small, gradual adjustments to existing policies are made or introducing minor changes over time, rather than implementing large-scale reforms all at once (42). This policy approach aligns with our findings of the gradual adaptations of CRTs that now include embedding a mental health professional within the teams. An incremental approach to policymaking is advantageous as it allows decision-makers to address evolving circumstances, provides flexibility to adapt to various contexts and is generally more widely accepted among stakeholders (61). At the same time, critics argue that incrementalism results in broader systemic issues being unaddressed, may stifle innovation and result in a resistance to change (62). Our framework also reflects this drawback particularly in the inability of CRTs to have an impact on structural issues and questionable results at both systems and individual levels (Appendix C, Figure C1).

Furthermore, our framework demonstrates the adaptability of CRTs, where, once a technique or intervention is implemented, it tends to be consistently readopted and considered as a “natural” response. In the case of CRTs, this persistence occurs despite mixed or limited evidence regarding their effectiveness. Additionally, while the rationale for implementing CRTs continues to identify structural issues (e.g., deinstitutionalization), challenges thereof at the systems level (e.g., police encounters with PIC) and individual level effects (e.g., rising numbers of PIC), the approaches taken remain a variation of the same “…(compared to the almost infinite variety of possible responses) because the new situation is responded to like something already

known, or some element of it" (42, p. 612). Incremental changes, as exemplified by the adaptability and acceptance of CRTs, avoid disrupting the status quo. However, policymakers who lean on CRTs, opting for marginal adjustments to "accommodate distinctive features of new situations" (62), may perpetuate ineffective polices and miss opportunities for transformative change.

Strengths and limitations of the study

The main strength of this study is the use of the CIS method, which is well suited for studies where conceptual clarity varies; this is the case for CRTs given the multiple models of delivery and implementation. CIS allows for broad data collection, enabling us to draw an extensive range of documents to inform our framework. To our knowledge, this is also the first study to draw on CIS methodology to garner insight about CRTs. It created the opportunity to locate the data within policy development, implementation, and the system arrangements taxonomy to offer additional insight, particularly where gaps exist in the delivery and implementation elements, for future consideration. These insights are significant given that CRTs continue to be implemented.

The various crisis response models, features, and modifications made it challenging to capture everything, and because literature in this area often refers to the same studies, the process at times was messy and incoherent, particularly in attempting to organize data within delivery arrangements. We recommend that researchers interested in the specific features of CRTs refer to the work of Puntis et al. (17), Rodgers (53), and Paton (63).

Implications for policy and practice

CRTs require clearer policies that address political systems factors and system arrangements, including funding, delivery, and implementation; a financial infrastructure; and

resources for PIC. Specifically, policies need to establish roles of providers and an evaluation plan. These policies should move to operationalize the formation of these teams beyond partnership, collaboration, and coordination—indeed, these terms need to be explained more thoroughly. We propose that when considering developing and/or implementing a CRT, to explicitly define the core features using systems evidence-informed system taxonomies which will aid with transparency and future evaluations of CRTs. We further suggest that jurisdictions aiming to develop and implement CRTs consider following the guidance from the Global Commission on Evidence, which outlines ways that evidence can be used and/or developed at all levels of the decision-making process (64).

Conclusion

The study of CRTs remains relevant in the field of crisis response, particularly as there is a growing emphasis on exploring alternatives that do not involve law enforcement, a significant policy concern. Our attempt to synthesize the current literature on CRTs that consist of police, health and mental health professionals, coupled with a critical interpretation of the evidence, involves constructing a framework that explains their adaptation and persistence. This contribution provides an account of CRTs that has not been extensively addressed in existing literature. Notably, our findings offer insights that take into consideration policy legacies, adding complexity to the implementation of alternative approaches. For readers advocating for CRT models without law enforcement, we aim to demonstrate, by locating CRTs within the context of incremental decisionmaking, why challenges to the existing system persist. Finally, we demonstrate that structures, systems, and individuals operate in interaction and emphasizes that models seeking lasting change must address all three components.

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Appendix A: Literature Search Strategy

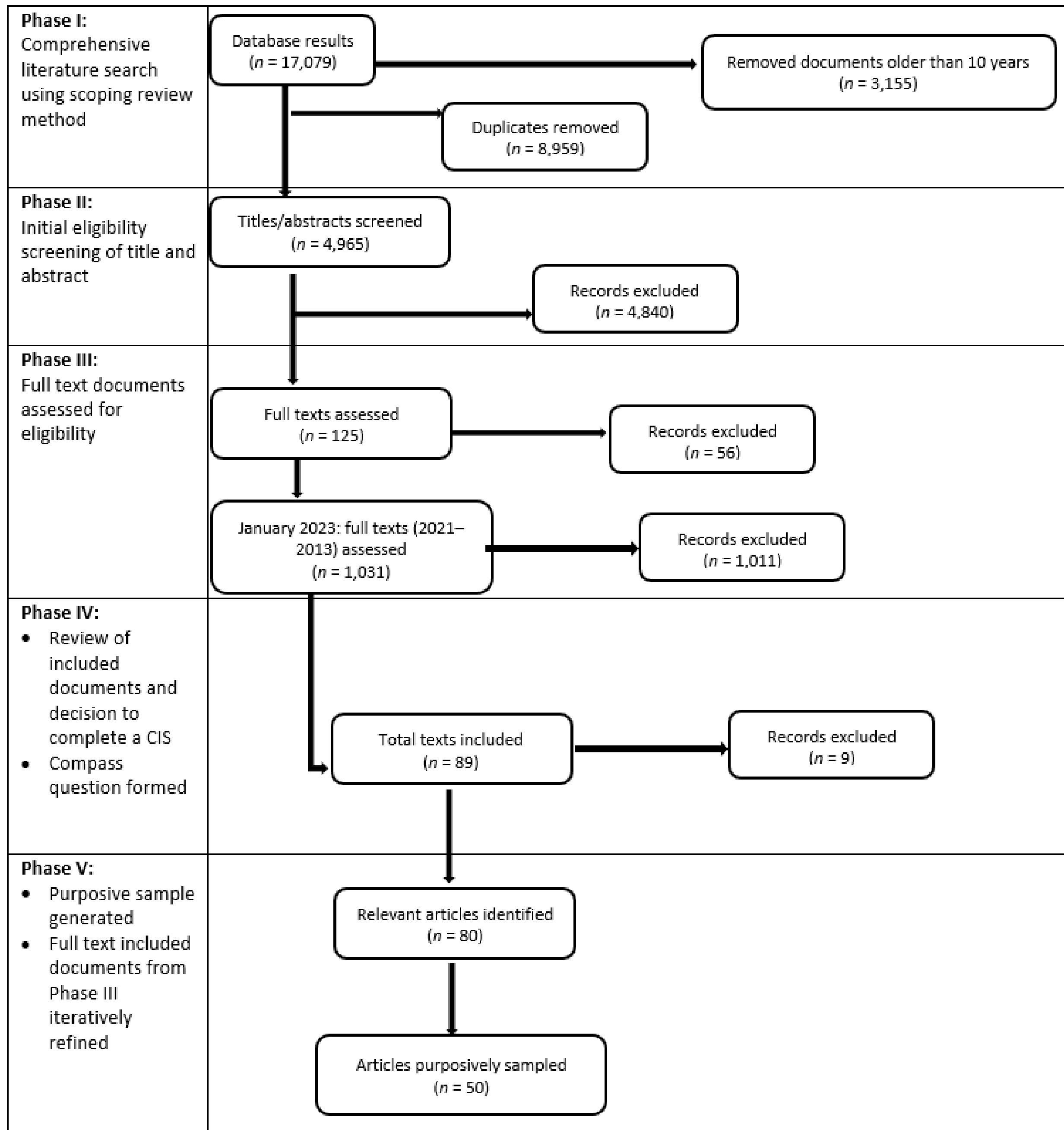
Table A1. *Health Sciences Search Terms and Results*

Database name	Search strategy	Results
Ovid, Embase, PhyschInfo, MedLine	(police/Police or Policing or law enforcement/Law enforce*).mp. AND exp (mental health/mental health or crisis or mental* ill* or emotionally disturbed person* or substance abuse/substance abuse).mp. AND (crisis intervention/coresponse or model* or team* or partnership* or scheme* or framework* or crisis intervention or CIT or co-respon*).mp.	3,706
Web of Science, Core Collection	(police/Police or Policing or law enforcement/Law enforce*).mp. AND exp (mental health/mental health or crisis or mental* ill* or emotionally disturbed person* or substance abuse/substance abuse).mp. AND (crisis intervention/coresponse or model* or team* or partnership* or scheme* or framework* or crisis intervention or CIT or co-respon*).mp.	2,567
EBSCOhost, CINAHL, Criminal Justice Abstracts, Humanities & Social Sciences Index Retrospective: 1907–1984, Social Sciences Index Retrospective: 1907–1983, Social Work Abstracts	(police/Police or Policing or law enforcement/Law enforce*).mp. AND exp (mental health/mental health or crisis or mental* ill* or emotionally disturbed person* or substance abuse/substance abuse).mp. AND (crisis intervention/coresponse or model* or team* or partnership* or scheme* or framework* or crisis intervention or CIT or co-respon*).mp.	2,403
ProQuest, Canadian Research Index, Dissertations & Theses, EconLit, International Bibliography of the Social Sciences (IBSS), Politics Collection, ProQuest Dissertations & Theses Global, Sociology Collection	((ab(police) OR AB(policing) OR ab(law enforce*)) AND (ab(mental health) OR ab(ment* ill*) OR ab(crisis) OR ab(substance use OR substance abuse OR drug use OR drug abuse OR dependence OR addiction) OR ab(emotionally disturbed person) OR ab(substance-related disorders)) AND (ab(crisis intervention) OR ab(coresponse) OR ab(co-response) OR ab(model*) OR ab(team*) OR ab(partnership*) OR ab(scheme*) OR ab(framework*) OR ab(CIT))) AND la.exact("ENG")	2,872
Total		11,548

Table A2. *Social Sciences Search Terms and Results*

Database name	Search Strategy	Results
Ovid, Embase, PhyschInfo, MedLine	(police or policing or "law enforcement").sh. or (police or policing or "law enforcement").ti. or (police or policing or "law enforcement").ab. AND (crisis or "mental health" or "mental illness").sh. or (crisis or "mental health" or "mental illness").ti. or (crisis or "mental health" or "mental illness").ab. AND (model or co-response or teams or intervention or prepare* or response).sh. or (model or co-response or teams or intervention or prepare* or response).ti. or (model or co-response or teams or intervention or prepare* or response).ab.	2,648
Web of Science	TS=(police OR policing OR "law enforcement") AND TS= (crisis OR "mental health" OR "mental illness") AND (model OR co-response OR teams OR intervention OR prepare* OR response)	1,579
EBSCOhost, CINAHL, Criminal Justice Abstracts, Humanities & Social Sciences Index Retrospective: 1907–1984, Social Sciences Index Retrospective: 1907–1983, Social Work Abstracts	((police OR policing OR "law enforcement")) AND SU ((crisis OR "mental health" OR "mental illness")) AND SU ((model OR co-response OR teams OR intervention OR prepare* OR response))	490
ProQuest, Canadian Research Index, Dissertations & Theses, EconLit, International Bibliography of the Social Sciences (IBSS), Politics Collection, ProQuest Dissertations & Theses Global, Sociology Collection	noft((police OR policing OR "law enforcement")) AND su((crisis OR "mental health" OR "mental illness")) AND su((model OR co-response OR teams OR intervention OR prepare* OR response)) AND la.exact("English")	661
Ingenta Connect	Title, keywords or abstract contains (police OR policing OR law enforcement) AND (crisis OR mental health OR mental illness) AND (model OR coresponse OR teams OR intervention OR prepare OR response)	153
Total		5,531

Figure A1. *Study Evolution*



Appendix B: Conceptual Mapping

Table B1. *Details of Documents Included in the CIS*

Variable	*n*	%
Year of publication		
2010–2013	9	11.00
2014–2018	42	52.50
2019	3	4.00
2020–2022	26	32.50
Country		
United States	31	38.75
United Kingdom	20	25.00
Australia	13	16.25
Canada	12	15.00
Denmark	1	1.25
New Zealand	1	1.25
Netherlands	1	1.25
Type of research		
Primary research	58	72.50
Nonempirical papers	22	27.50

Table B2. *Organizing Framework of Factors Addressing Compass Question Domains*

Factors related to compass question domains	Descriptors	All articles (*N* = 80)	E (*n* = 58)	NE (*n* = 22)
	Conditions under which teams are formed			
Factors related to how governments set agendas	What drives attention and prioritization of issues to address			
Attention to problems	Focusing events, changes in indicators, feedback from existing programs	58	46	12
Generation of policy proposals	Diffusion of ideas, feedback existing policies, communication, persuasion	21	12	9
Political events	Swings in national mood, role of organized interests and events within government	14	9	5
Decision agenda	How some issues are prioritized for active decision	29	18	11
Policy entrepreneur	Policy actors who can directly influence agendas	5	1	4
Political factors that shape policy choices (3i+E)				
Institutions	Policy legacies, policy networks, and government structures	68	51	19
Interests	Actors who benefit or bear costs of policy decisions	23	16	7
Ideas	Evidence and values	20	17	3
External factors	Major reports, high profile cases, court decisions	20	10	10
	Features			
Program and service areas included				
Policing		73	53	20
Health		69	49	20
Community and social services		11	7	4
System features				
Governance	Levels of decision-making; stakeholder and consumer participation in decision-making process	58	39	19

Factors related to compass question domains	Descriptors	All articles (*N* = 80)	E (*n* = 58)	NE (*n* = 22)
Financial	How systems are financed, provider remuneration	14	10	4
Delivery	How programs and services are designed to meet the needs of the consumer, who provides them, and with what supports are they provided	66	48	18
Implementation strategies	How programs and services target providers, consumers, and organizations, including education components	55	36	19
Outcomes				
Population level		4	3	1
Diversion from CJS and/or ED		56	42	14
Provider experience		46	34	12
Client experiences		23	17	6
Cost-effectiveness		15	9	6
Effectiveness		25	21	4

Note. E = empirical articles; NE = nonempirical articles.

Appendix C: Conceptual Framework and Related Insights

Figure C1. *Conceptual Framework*

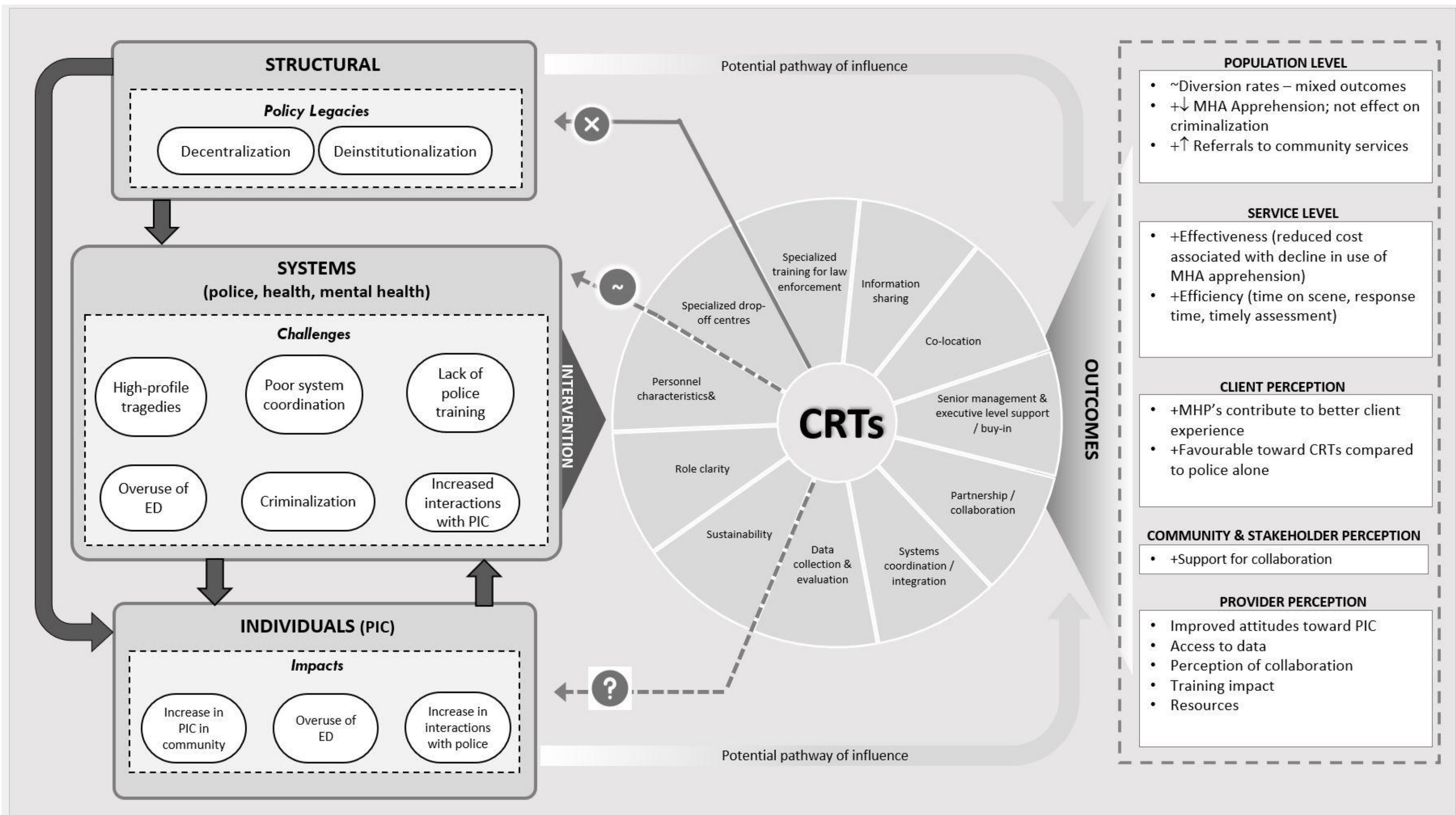


Table C1. *Key Insights About Conditions Under Which Crisis Response Teams Are Formed*

Framework element and related theme	Conditions under which CRTs are formed	Sources
Agenda setting framework: Problem		
Criminalization of people with mental health issues	• People with mental health issues become frequently entangled with the CJS and are overrepresented across the CJS continuum. Their interaction with police can result in arrest and processing through the courts. • Police become gatekeepers between the mental health system and CJS, which contributes to arrest rates of individuals with mental health issues rather than referring to treatment through hospitalization.	(3, 5, 14, 15, 18, 27-29, 31, 33, 35, 36, 39, 51, 56, 57, 60, 65)
Increase in number of people with mental health issues	• Rise in mental health issues every year, many of which result in encounters with the police. The demand levels created by mental health has put pressures on the health system and contributes to increased calls to police for support.	(4, 5, 28-31, 51, 53, 58, 66, 67)
Rise in police interactions with people with mental health issues	• Police calls to situations involving people with mental health issues have risen, which places demand on police to become de-facto mental health responders.	(3, 5, 15, 27, 28, 31-33, 37, 44, 45, 56, 59, 65, 68)
Police lack of expertise and skills in responding to people with mental health issues	• Police perceive themselves as inadequately prepared to provide mental health crisis support, lacking the necessary skills to support people with mental health issues.	(4, 5, 16-18, 33, 35, 36, 40, 42, 48, 49, 51, 53, 54, 58, 60)
Health and police system issues in responding to people with mental health issues	• People experiencing mental health issues often receive inadequate support in the health system, specifically the ED. Both the CJS and health system face increasing challenges to meet the needs and growing number of people with mental health issues and who are in crisis. • Lack of service coordination places considerable pressure on health and police systems to address emergency mental health issues.	(34, 35, 57, 60)
Overuse of ED by people with mental health issues	• Increase in presentations to EDs and overuse thereof have placed a significant financial burden on communities. EDs are often ill-equipped to provide treatment for people with mental health issues and who are in crisis.	(5, 44, 52, 57)

Framework element and related theme	Conditions under which CRTs are formed	Sources
	• Mental health-related presentations in EDs experience long delays and/or quick discharge without being stabilized or provided with follow-up and/or treatment planning.	
Use of police resources	• Absence of adequate mental health resources places responsibility on police services to manage mental health situations. This detracts from police role of public safety and directing resources toward managing mental health crisis response systems. • Call to police for mental health support absorb police resources, including increased calls for service, transportation, and waiting in the ED; such calls take longer to address compared to an average police call.	(5, 18, 29, 31, 40, 42, 57)
Agenda setting framework: Policies		
Focus of policies aimed at alternative response to criminalization, apprehension, and use of the ED	• There is a consensus that police services need to establish links with mental health and health services to provide care and management for people with mental health issues. Policies are aimed at establishing collaboration between these systems to improve response to people with mental health issues. The intent of such collaborations is viewed as an alternative to ED and CJS use for mental health needs. Thus, CRTs are viewed as an alternative to these formal means and aim to divert people with mental health issues from formal/traditional systems.	(16, 18, 27, 29-31, 35-37, 41, 46, 49, 53, 57, 65, 68, 69)
Agenda setting framework: Politics		
Public response to high profile tragedies involving police interaction with people with mental health issues	• Highly publicized shootings of people with mental health issues and public outrage in response to such tragedies has prompted police services to incorporate CRTs.	(3, 29-31, 35, 38-42, 57)
Government support for and encouragement of partnerships between police, health, and mental health systems.	• Legislation and policy frameworks that support collaboration between police, health, and mental health services have become a top priority for governments in response to rising demands on system resources, public outcry to publicized tragedies between police and people with mental health issues, and the belief that partnerships across systems are needed to manage mental health service requests.	(3, 29-31, 35, 38-42, 57)
Policy D&I: Institutions		
Policy legacies comprising deinstitutionalization and changes to mental health laws	• Policies aimed at coordinating services to address the consequences of deinstitutionalization, and which align with police and health system goals of	(5, 18, 27, 30, 31, 33, 35, 36, 38, 40, 44, 46,

Framework element and related theme	Conditions under which CRTs are formed	Sources
	diversion and responding to needs of people with mental health issues, are more likely to be prioritized. • Since the era of deinstitutionalization, people with mental health issues have been left with few community resources. Communities have become saturated with people experiencing mental health issues and without adequate care and treatment. Problems with treating mental health issues and program delivery issues have created conditions whereby police have become the primary responders to mental health calls for service. • Changes to mental health legislation postdeinstitutionalization became a guideline for police services when responding to mental health calls for service, enabling police to involuntarily detain people with mental health issues. Police use this option because it is a simple way of resolving calls for service, yet it also contributes to long wait times in the ED and criminalization of people with mental health issues.	51-53, 57, 59, 68, 70, 71)
Decentralization of government impacted service delivery of organizations	• Shifting of burden of responsibility onto communities for service delivery created the conditions whereby people with mental health issues were left with few resources or support for their mental health. Police have acted as key facilitators to coordinating services to address the barriers created by decentralized policy through integrated approaches to mental health and policing.	(5, 18, 27, 30, 31, 33, 35, 36, 38, 40, 44, 46, 51-53, 57, 59, 68, 70, 71)
Policy D&I: Interests		
Police, health, and mental health interest group alignment (chiefly among police) on alternative pathways to divert from the CJS and ED	• Given the recognition that police alone cannot respond to the needs and demands of calls to people with mental health issues, coupled with issues of criminalization and burden on ED, focus has shifted to divert these individuals from these systems by implementing alternative models of response (i.e., CRTs).	(4, 5, 9, 14, 16, 18, 27, 29, 30, 37, 38, 43-46, 48, 50, 52, 57, 59, 60, 66, 67, 71)
Interest group partnership and collaboration are critical to generate enthusiasm to design, fund, and implement CRTs	• Interest group recognition that CRTs can be beneficial in reducing the need for crisis response by police services and increasing access to other services for people with mental health issues—this notion requires considerable effort from police, health, and mental health services.	(4, 5, 9, 14, 16, 18, 27, 29, 30, 37, 38, 43-46, 48, 50, 52, 57, 59, 60, 66, 67, 71)

Framework element and related theme	Conditions under which CRTs are formed	Sources
	• Interest group collaboration can enable information sharing, joint decision-making, and coordinated intervention, with aims to improve outcomes for people with mental health issues and contribute to effectiveness of services.	
Policy D&I: Ideas		
Knowledge and beliefs (evidence)	• Rationale for CRTs and need for services to collaborate draws on evidence demonstrating that police are frequently mental health service providers stemming from calls for service. Evidence also shows that people with mental health issues increasingly present in the ED, are in crisis, and have encounters with police, some of which result in tragedies. • Increased awareness that people with mental health issues are on the rise as a population, suggesting a need for services to provide care for these individuals. • The flexibility of CRTs is beneficial to police, as they can be tailored to the needs of individual communities. • Evidence indicates that successful approaches to connect people with mental health issues to appropriate services in lieu of EDs and the CJS require collaboration.	(4, 5, 18, 27-32, 35, 39, 42-44, 48, 49, 57, 67, 70, 71)
Values and mass opinion	• Shift in perspective toward decriminalizing mental illness, reducing stigma, and providing care in the community. • Increased focus on providing timely support and intervention for people with mental health issues while easing the pressure on health and police services.	(4, 5, 18, 27-32, 35, 39, 42-44, 48, 49, 57, 67, 70, 71)
Policy D&I: External factors		
Major reports and inquests into preventable killings of unarmed individuals in police custody show that these individuals presented with mental health history.	• Recommendations encourage the development and implementation of collaborative programs and partnerships between police, the health system, and community mental health programs and services. This includes having the presence of a mental health professional available alongside police. • High-profile shootings of people with mental health issues by police prompted questions about the role of police in responding to mental health service calls. As a result, police services began to engage in collaborative approaches to better respond to people with mental health issues. CRTs appear to emerge in the aftermath of high-profile tragedies involving police encounters with people with mental health issues.	(4, 18, 27, 29, 30, 33, 38, 39, 41, 49, 50, 53, 57, 58, 60)

Note. D&I = development and implementation.

Appendix D: Taxonomy of Evidence

Table D1

Governance and Financial Arrangements

Relevant theme	Arrangement	Key examples from literature	Barriers	Facilitators	Sources
Policy authority	Centralization/ decentralization of policy authority	Governance and accountability are key to ensuring that crisis services operate as an organized and coordinated system.	Challenges to coordination across various systems may be challenging.	Decentralization of services viewed as better for meeting local demands; services can coordinate/collaborate based on community needs.	(27, 41, 42)
Organizational authority	Management approaches	Senior and executive level support for CRTs is critical to implementation.	Front-line staff may feel less supported and/or lack clarity around their roles in a crisis response team (i.e., operational issues) if senior management is not involved.	Strong organizational buy-in, executive level support, views of police chiefs and creation of interagency committees are strong factors of influence for adoption and implementation of CRTs.	(18, 49, 51)
	Networks/ multi-institutional arrangements	Partnership and collaboration between police, health, and mental health services, including history of collaboration, are crucial elements of CRTs.	Inconsistent staffing arrangements may result in irregular operation from both police and health provider; lack of integration and coordination can affect service referrals and access to non-police services; confusion in	Collaborative planning and implementation across systems, information sharing, strong interagency relationships, respect, trust were viewed as integral to program implementation; increased recognition that police, health, and mental health systems must work	(17, 27, 30, 31, 33, 37, 45, 46, 49, 50, 52-55)

Relevant theme	Arrangement	Key examples from literature	Barriers	Facilitators	Sources
			role clarity in relation to decision-making between police officer and mental health worker can impede response.	together to meet the needs of people with mental health issues.	
Consumer & stakeholder involvement	Consumer participation in service delivery	Stakeholder engagement and input may garner support and enthusiasm for designing, funding, and implementing CRTs; appropriate referral to community services, follow-up, and participation in decision-making about care can divert people with mental health issues from CJS and ED.	Scarcity of research on involvement of consumer in design, implementation, and evaluation of CRTs.	Service user feedback can help monitor performance; developing evaluation plans that account for disproportionate demand by repeat service users.	(5, 9, 18, 27, 30, 33, 37, 39, 43-46, 50, 57, 59)
Financial arrangements	Health and/or police funding or mix of funding	Lack of clarity around funding for CRTs in literature (i.e., entire financing structure) and financial arrangements across collaborative agencies/services.	Crisis services are funded and regulated at the state or local level and draw on multiple funding sources.		(27, 28, 31, 34, 46, 49, 53, 56, 57)

Table D2

Delivery Arrangements

Relevant theme	Arrangement	Key examples from literature	Barriers	Facilitators	Sources
How care is designed to meet consumers' needs					
Availability of care		Expanding availability of CRTs to 24hrs is crucial and considered a reliable resource	• Lack of funding and inconsistent availability of CRTs are a hinderance. • Lack of availability of community services such as specialized drop-off facilities is a barrier when attempting to divert/refer people with mental health issues to local mental health supports	Recognition within policing, health, and mental health systems that coordination is needed to better support people with mental health issues	(18, 29, 31, 34, 35, 38, 40, 42, 46, 49, 52, 55, 58)
By whom are services provided	System—need, demand and supply	Need for partnership and collaboration across systems; need for police training about mental health issues; police may be inclined to apprehend under mental health legislation if unable to refer to adequate mental health supports; need for mental health professionals to support police (and people with mental health issues)	Lack of police training/education about mental health issues contributes to poor outcomes during interactions with people with mental health issues; operationalization issues (i.e., need for some standardization and professionalization) to ensure effective distribution of resources and accountability; variation across crisis response	Incorporating crisis intervention training for police and comprehensive training of police and mental health workers on CRTs	(17, 18, 29, 31, 34, 35, 37, 38, 40, 42, 46, 49, 52, 55, 58)

Relevant theme	Arrangement	Key examples from literature	Barriers	Facilitators	Sources
			models is a challenge to standardization and evaluation		
	Skill mix—multi-disciplinary teams (CRTs)	Collaborative partnerships between police, health, and mental health providers in the form of CRTs need to balance standardization, common outcome measures, provide training for police about mental health issues and about police procedures for mental health professionals. Tailoring crisis response team interventions requires tailoring, implementation and integration of services at the local and regional levels. Partnerships, integration and protocols can affect how mental health issues, crises and safety for people with mental health issues.	Availability and access to CRTs—when these teams are not available 24hrs or availability is limited, police may revert to apprehensions.	Strong partnerships, coordination, training is viewed as key to model success.	(17, 18, 29, 31, 34, 35, 37, 38, 40, 42, 46, 49, 52, 55, 58)
	Staff—training	Specialized training and education for police officers about mental health are crucial for interactions with people with mental health issues, efficacy of referrals and relationship development among team members.	The bridging of cultures and perspectives (police, health, and mental health systems) can be a barrier if training, protocols, and integration are not operationalized.	Collaborative partnerships and police training about mental health are crucial to CRTs.	(5, 16, 18, 37, 38, 40, 42, 45, 46, 48, 55, 58, 59)

Table D3

Implementation Strategies

Key features	Key insights from the literature	Implementation barriers	Sources
Partnership, collaboration, coordination, and integration	• Qualitative evidence emphasizes strong partnerships between police, health, and mental health services are integral to CRTs and to meeting needs of people with mental health issues • Partnership between police officers and mental health professionals are important for service delivery • Collaboration is a foundational component of CRTs • Collaborative planning and integration, strong network integration to facilitate linkage and referrals of people with mental health issues and referral services • Planning, coordination, and interagency networks improve systems of triage	• Challenges in collaboration between police and health system cultures • Lack of a coordinated mental health system and services including case management may be a barrier to access to services • Multiple pathways to mental health system and services • Poor coordination can lead to service provision delays • Difficulty managing and maintaining system partnerships • Navigating partnership vs ownership of a crisis response team can be a barrier to establishing partnerships • Ensuring that organizational structures are formed/in place to support crisis response initiatives/operations	(18, 37, 49, 51, 53, 60)
Senior management/ executive level support/buy-in	• Crisis response teams that are supported and endorsed by senior/executive level have a significant impact on implementation and sustainability and organizational change. • Creation of interagency committees at the senior operational level foster problem resolution, information sharing, guide implementation and program promotion.	• When there is a lack of knowledge in a police organization about CRTs, they are more likely to be underutilized.	(18, 49, 51, 54)

Key features	Key insights from the literature	Implementation barriers	Sources
	• Police chiefs have a strong influence in the adoption, implementation, and endorsement of CRTs.		
Specialized training for law enforcement	• Specialized training for police officers, specifically CIT training improves officer knowledge about mental health issues and contribute to improved outcomes for people with mental health issues in encounters with police. • Ongoing training of police officers creates an opportunity for a pool of appropriately trained officers. • Comprehensive training of police and mental health professionals is essential to program success.	• When cross-sectoral training for police and mental health professionals is not provided, challenges such as limited knowledge and understanding about each system's working cultures may affect working relationship.	(9, 18, 30, 31, 37, 45, 49, 51, 53, 54, 57, 59, 60)
Information sharing	• Information sharing between police, health, and mental health are key to effective interagency working, ensure accurate decisions are made about care and risk and overall decision-making.	• Potential concerns regarding sharing of confidential/sensitive information with police can compromise client confidentiality. • Completing a mental health assessment in in public can pose a privacy challenge to person's health information. • Co-location can help offset the exchange information.	(34, 49, 51, 53)
Co-location	• Co-location where crisis response team members from across systems come together are beneficial for team members including information-sharing, relationship/team building and interaction.		(18, 49, 51, 59)

Key features	Key insights from the literature	Implementation barriers	Sources
Specialized drop-off centres	• When available and specifically with a no-refusal policy, specialized drop-off centres can assist crisis response team members transport a person with mental health issues to additional supports and divert from ED and CJS, provide streamlined intake, mental health support and follow-up. • Memoranda of understanding are an efficient process to ensure that transports (by officers and CRTs) are given priority while guaranteeing that the person will be assessed.	• Largely depends on availability of mental health services in a community. • Lack of crisis centres may result in reverting to use of ED (thereby impacting ED wait times) or apprehension (thereby reverting to use of CJS).	(18, 29, 33, 49, 59)
Role clarity, personnel characteristics and competencies	• Team's interest in mental health is important to how the team operates. • Roles, responsibilities, and reciprocal arrangements need to be clearly defined between crisis teams and other related health services. • Need for and importance of recognition of role differences between police and mental health professional for optimal teamwork and service delivery. • Establishing lines of accountability and responsibility for such decision-making is critical to resolving an incident.	• Lack of awareness about CRTs or poor exposure across police divisions can hinder use or lead to low and/or inappropriate use. • Police officer buy-in to crisis response team initiative is key. Navigating police officers 'natural' suspicion of outsiders can impede the trust-building among team members. • Ensuring a good fit between mental health professional and police officer particularly at the hiring stage of a clinician for a crisis response team can help reduce turnover. • Cultural and values clashes and differences in mandates and goals from healthcare workers and police officers are presented as barriers in literature • Inconsistent staffing arrangements.	(37, 46, 49)

Key features	Key insights from the literature	Implementation barriers	Sources
Sustainability	• Concerns over program sustainability and drift over time raised in literature	• Lack of clarity about role of CRTs (their purpose) in general and among community, response times and capacity to address needs raises concerns about their added value	(18, 37, 53)
Data collection and evaluation	• Evaluations pertaining to crisis response team programs demonstrate promising but mixed results. • Evidence is largely anecdotal. • Existing data systems may not accurately or adequately report program activities and outcomes. • Limited evaluation and information about effectiveness of CRTs or findings across studies produce mixed results. • Despite being popular among police and health professions and significant investment in CRTs, there is a lack of evidence for crisis response team models. • U.S. studies show that outcomes that measure perception and views demonstrate a stronger effect versus objective outcomes.	• Lack of evaluation plan at inception is a major challenge. • Variations across crisis response models and their presentation in literature leads to a lack of precise reporting. • Incomplete and inconsistent data collection limits opportunities for evaluation. • Methods for comprehensive, accurate, and efficient data collection are needed. • Protocols for data collection across agencies require development. • In some jurisdictions, there is limited or no possibility to track mental health calls.	(17, 33, 38, 40, 45, 46, 49, 54, 58, 63, 67, 69)

Appendix E: Outcome Classifications

Outcome classification	Key themes	Examples from literature	Sources
Population level outcomes	Diversion rates		
	Diversion from the CJS	• Little evidence that CRTs reduce subsequent jail bookings. • Some evidence that CRTs reduce reincarceration risk among Black individuals. • Some evidence points to CRTs mitigating a reduction in arrests and use of police custody. • Questions remain as to whether people with mental health issues are diverted from the CJS in the long-term.	(5, 9, 17, 18, 30, 34, 44, 45, 48, 51, 54, 57, 59)
	Diversion from the ED	• Evidence suggests that hospital admissions are reduced. In cases where hospital admissions increase, it is believed that these were more appropriate admissions while reducing ED visits by use of alternative resources.	(5, 9, 17, 18, 30, 34, 44, 45, 48, 51, 54, 57, 59)
	Apprehension rates		
	Apprehension under Mental Health Act	• Crisis response models were more likely to escort to ED, but these were less likely to be involuntary.	(14, 17, 18, 30, 33, 40, 43, 48, 51, 53, 54, 56, 60, 67)
	Police arrest and use of force	• Mixed results, although evidence leans toward an insignificant effect on use of force. Particularly, CIT training appears to have no impact on reducing arrests and/or use of force. • Although CRTs are associated with less use of force and procedural justice, there is no difference in perceived coercion.	(14, 17, 18, 30, 33, 40, 43, 48, 51, 53, 54, 56, 60, 67)
	Referrals		
	Establishing links with other services	• CRTs open up pathways to referrals to other services (e.g., housing, treatment). • There is in increase in access to community services and demonstrate a greater engagement with these services by people with mental health issues. • Quantity and quality of community referrals enhanced through CRTs.	(4, 5, 14, 17, 18, 30, 40, 45, 46, 51, 53, 59, 60)

Outcome classification	Key themes	Examples from literature	Sources
	Number of repeat interventions since referral	• Evidence of both increase and reduction in repeat intervention depending on jurisdiction.	(17, 18, 45, 70)
Service level outcomes	Effectiveness		
	Cost-effectiveness	• Programs can be cost-effective, demonstrated by cost savings per case when CRTs were involved compared to police alone; reduction based on reduction in hospital admission and ED wait times.	(5, 17, 18, 40, 44, 53)
	Efficiency		
	Response time	• Timely access to mental health crisis assessment by CRT response compared to ED. • Response time to scene varied, ranging from 30 min or less to substantially delayed.	(5, 18, 44, 45, 48, 51, 53, 67)
	Time spent in the ED	• Evidence in reduction of time spent in ED by CRT compared with patrol officer alone.	(5, 9, 30, 43, 44, 51)
	Time spent on scene	• Because user needs assessments are completed on scene by CRTs, it frees up other response officers. • Studies in U.S. and Canada show that time spent on scene is reduced, and in areas where enhanced mental health services exist, time spent on scene can significantly decrease.	(9, 17, 18, 45, 51, 53, 54)
Client perception outcomes	Presence of mental health worker		
	Presence is a significant factor in perceptions of and experiences with CRTs	• Mental health professionals' role in deescalation, communication, compassion, and mental health knowledge contribute to better client experience. • Feedback toward co-response models was more favourable compared to police alone.	(51, 53)
Community and stakeholder	Collaboration		
	Support for collaboration by stakeholders	• General support for collaboration between police and mental professionals. • Perception that CRTs meeting goals of diverting people with mental health issues from CJS and ED.	(18, 37, 51, 53)

Outcome classification	Key themes	Examples from literature	Sources
perception outcomes		• Viewed CRTs as valuable to meeting needs of people with mental health issues. • Some stakeholders feel that CRTs should be first responders instead of secondary response. • Positive effects on quality-of-care by all stakeholders: police, health staff and service users all noted an improvement in the quality of care.	
Provider perception outcomes	Attitudes toward people with mental health issues		
	Improvement in officers' perception of people with mental health issues	• Officers who work on CRTs improved understanding and perception of mental health issues.	(18, 43, 54)
	Access to data		
	Access to information increases confidence in decision-making	• Access to immediate metal health information enables better care planning, consider the context of the service user including care planning; also helpful for guidance, alternative and advice regarding courses of action.	(43, 49, 53)
	Perception of collaboration		
	Collaboration between police and mental health professionals enables a better response to people with mental health issues	• CRTs bring about strong partnerships between mental health and police, contributing to better de-escalation skills in encounters with people with mental health issues. • Some concern for safety to mental health worker when attending calls to mental health crises with police officers.	(15, 17, 18, 34, 37, 45, 46, 49, 54)
	Training		

Outcome classification	Key themes	Examples from literature	Sources
	CIT training has a significant impact on police officers' knowledge about mental health	• CIT training improves confidence in police officer approach to people with mental health issues including knowledge about symptoms of mental illness. • Officers with highest level of training had more positive attitudes toward people with mental health issues living in the community.	(51, 53, 67)
	Resources		
	Funding, research, and availability of CRTs	• Funding challenges translate to availability of CRTs, particularly mental health workers. A shortage of mental health professionals is reported and contributes to staff turnover rates. • Lack of social supports and resources for mental health issues produces challenges to referrals. • More research needed to demonstrate effectiveness of CRTs which translates to funding opportunities to implement these teams.	(15, 33, 46, 53)

Chapter 3: Study 2

Preface

This chapter presents a case study to examine how and why a CRT is developed and implemented. Building on knowledge from the previous chapter, I wanted to obtain a first-hand account from individuals who conceived of, and were responsible for, Ontario's first mobile crisis rapid response team (MCRRT) model. The MCRRT pairs a police officer and mental health professional in a police vehicle to respond to 911 calls to mental health crisis and is considered a first responder CRT model. I designed the study with the guidance of my faculty supervisor and my dissertation committee. I was responsible for developing the interview guide and all data collection and analysis. Data collection took place in person in 2018 as well as via Skype and Zoom between 2020 and 2021 due to the pandemic. During the review stages, my supervisor initially provided guidance and feedback and thereafter my committee provided additional feedback, which was incorporated into subsequent drafts.

Responding to People in Crisis: A Policy Analysis of the Hamilton Mobile Crisis Rapid Response Team (MCRRT) Model

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Keywords: people in crisis, PIC, mobile crisis response team model, MCRRT, Hamilton mobile crisis rapid response team, policy analysis, agenda setting, policy choice

Word count: 8,998 (main text) 14,165 including tables and figures

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Abstract

Background: The Mobile Crisis Rapid Response Team (MCRRT) model is a partnership between a local police service, a schedule 1 hospital, and mental health services to respond to mental health and addiction calls through 911 dispatch. A crisis-trained police officer and a mental health professional respond together to a person in crisis (PIC) and determine how best to resolve the situation. This paper examines how and why the MCRRT model was developed and adopted in Hamilton, Canada. **Methods:** We used a qualitative case study design involving document analysis ($N = 36$) and comprehensive semi-structured interviews with MCRRT leaders ($N = 5$). We applied frameworks that explain government agenda setting and policy choices to organize the preliminary data, and then refined the data to identify themes and generate an in-depth analysis. **Results:** Attention to the issue was initially driven by what key stakeholders viewed as a compelling problem: the increasing frequency of contact between police and PIC, the high numbers of PIC being admitted to emergency departments, and the corresponding high costs and suboptimal care received by PIC. The only real policy alternative that was considered was the MCRRT, which was further substantiated by absence of political desire to consider alternatives to the status quo. **Conclusions:** This analysis offers a snapshot of the factors that can be useful in proposing new initiatives that expand on the boundaries of existing programs. Decision-makers can strategically align their proposals within existing government directives in ways that incrementally build on existing structures and processes. Moreover, the findings provide a useful reference for aligning ideas within the context of structural interests to implement a program.

Keywords: Hamilton Mobile Crisis Rapid Response Team, MCRRT, agenda setting, 3i+E, people in crisis, policymaking

Introduction

Police in many countries have a long-standing history of responding to calls from people with mental health issues (PMI) who are in crisis (now more commonly referred to as people in crisis (PIC))[5], and evidence suggests that these situations are on the rise in Canada and elsewhere (Semple et al., 2021). According to Canadian data, police, on average experience an interaction with a PIC at least once per week (Schulenberg, 2015). These interactions continue to be ca challenge for police, particularly in light of high-profile cases of police shootings and public outrage in response to these tragedies (Bratina et al., 2021; Coleman & Cotton, 2014; Coleman & Cotton, 2016; Ghelani, 2022; Ghelani et al., 2022).

Commonly cited factors for increased interactions between police and PIC include the policy legacy of deinstitutionalization, poor system coordination and lack of community mental health resources (Coleman, 2014; Coleman & Cotton, 2016; Iacobucci, 2015; Livingston et al., 2014; Shore & Lavoie, 2019) and contribute to police being the primary responders to the emergency needs of people with mental health issues (Iacobucci, 2015). When responding to PIC, the rationale for intervening stems from police power and authority to protect the public, and the state's responsibility for protecting people (Fahim, 2016; Lamb et al., 2002). Lack of clinical expertise to approach and defuse complex situations involving PIC, police are more likely to apprehend them (Lamb et al., 1995; Watson et al., 2004). When officers are called to situations involving PIC, they "want and need rapid on-site assistance from mental health professionals" (Lamb et al., 2002, p. 115). What has become clear is that police, health care, and mental health systems and services need to work together where police provide security, and

[5] Police have historically referred to people with mental health concerns as a person with mental illness (PMI). This term is now being replaced with person in crisis (PIC), as police have come to realize that how these individuals are perceived and described is as important as the interventions undertaken with them (see for example, Iacobucci, 2015).

mental health professionals provide their knowledge and expertise about mental health (Lamb et al., 1995).

Amid the growing recognition that police alone cannot effectively respond to PIC, several models of crisis response have been implemented across North America (Koziarski et al., 2020; Lamanna et al., 2018; Lord & Bjerregaard, 2014; Rodgers et al., 2019; Shapiro et al., 2015). These models are often categorized as police-based specialized response, police-based mental health response, and mental health–based specialized response. These programs adhere to two mainstream models: the crisis intervention team (CIT) model (police-based specialized response) or the co-response model (combined police, health, and mental health response).

On April 21, 2015, a new model of crisis response, the Mobile Crisis Rapid Response Team (MCRRT) model, was implemented in Hamilton, Ontario, Canada. A distinguishing feature of the MCRRT is that both the police officer and the mental health professional are designated as first responders, making the MCRRT a first responder model. The MCRRT began as a pilot project in November 2013 in Ontario's Hamilton Niagara Haldimand Brant Local Health Integration Network (Fahim et al., 2016; Internal communication, 2012a, 2014a, 2014c, 2016a). MCRRT is a partnership between the Hamilton Police Service, St. Joseph's Healthcare Hamilton (a schedule 1 hospital), and a mental health service to respond to mental health and addiction calls through 911 dispatch, as first responders (Internal communication, 2012a) (Fahim et al., 2016). Prior to the MCRRT, Hamilton Police Service and St. Joseph's Healthcare Hamilton collaborated in crisis response through the Crisis Outreach and Support Team (COAST) model, which continues to be used today. As a community-based approach to crisis response, COAST pairs a mental health worker with a police officer as a secondary response,

meaning that once a general patrol officer deems a call to be safe, the call is handed over to COAST to provide additional support (Semple et al., 2021).

In contrast to COAST, MCRRT pairs a crisis-intervention trained police officer with a regulated mental health professional (nurse, social worker, or occupational therapist), who ride together in a police vehicle and provide 911 rapid response to PIC (Fahim et al., 2016; Internal communication, 2012a, 2012b, 2013b, 2014b, 2014c, 2015a, 2015b, 2016a). MCRRT responds to the call on site and determines how the situation can best be resolved. Options include resolving the crisis in the person's environment, connecting them with, or referring to, additional supports in the community, and taking them to the hospital. Since 2015, the MCRRT model has been funded across Southern Ontario including in Brantford, Halton, Norfolk and Haldimand Ontario Provincial Police (OPP) detachments in Simcoe and Cayuga, Strathroy-Middlesex, OPP Middlesex County and Strathroy-Caradoc Police Service Sudbury Police (Canadian Mental Health Association (CMHA) Thames Valley Addiction and Mental Health Services, 2024; Internal communication, 2013a; Sudbury Police Service, 2021).

To date, the process of how MCRRT was developed and adopted has not been studied, particularly from the perspective of key decision-makers involved in the process. Using Kingdon's agenda setting framework (Kingdon, 2003) and the 3i+E Framework (Gauvin, 2014), this paper examines the factors that led to the development and adoption of the MCRRT model as the policy choice to respond to PIC. Our research question was, how and why did key decision-makers from police, health, and mental health services come together to develop and implement MCRRT?

Methods

Study Design

We used a qualitative explanatory single-case study approach to examine how and why MCRRT was adopted in Hamilton, Ontario. Using Yin's (2014) explanatory single case design, which is most appropriate when asking how or why questions about a contemporary phenomenon over which the researchers have little control and where the research is a singular unit of analysis. A single-case study design allows for more extensive analysis and produces greater insights into the case. In this case, that analysis pertained to key decisions relating to MCRRT implementation. We also focused on the senior-most decision-makers, rather than analyzing multiple levels of administrative decision-making. Prior to recruiting participants for the study, ethical approval was obtained from the Hamilton Integrated Research Ethics Board (HiREB, Protocol #5649, see Appendix A for participant recruitment letter, Appendix B for interview invitation, and Appendix C for the interview guide).

Establishing the Case and Its Boundaries

A central component of a case study design is defining the case and its boundaries. This case is defined as the implementation of MCRRT: how and why did key decision-makers in police, health, and mental health in Hamilton, Ontario, decide to develop and implement the MCRRT? The case is bounded by the context of senior decision-makers, and only data pertaining to that context is included. The case is also bound by time, in that only data from the initial concept phase of the MCRRT, in 2014, to its initial outcomes in 2015, are included.

Data Sources

Two main sources of data collection informed this study. The first was documents, including publicly available major reports and media sources, as well as internal organizational

documents such as presentations, memos, and the MCRRT proposal (*N* = 36). The second was semi-structured interviews conducted with key participants (*N* = 5). Additionally, in 2015, AT was invited to attend a presentation on the background and rationale for MCRRT at Hamilton Police Service. The presentation source materials were shared with her, and she was invited to attend MCRRT meetings, observe some training, and participate in three ride-alongs. These latter sources of data are not included in this report, but they helped to identify significant documents and facilitated access to senior decision-makers.

Document Selection and Retrieval

Initially, AT reviewed presentations provided by St. Joseph's Healthcare Hamilton and Hamilton Police Service that contained information about major reports and/or recommendations used to substantiate MCRRT, including problem identification and policy solutions. Interview participants also guided her toward relevant documents that substantiated their decision-making in developing MCRRT. During the interview process, AT asked each participant to identify any reports or documents, government and otherwise, that were used to inform the development of MCRRT. She was provided with internal proposals, backgrounders, and a presentation from the Local Health Integration Network, which identified additional documents that were included in the analysis.

As well, AT searched the Ontario government documents database for documents published between 2013 and 2017 to determine whether any additional documents, not identified by interview participants, should be included. Keywords that were used to search the database were "mobile crisis response team*" OR "crisis response team*" OR "mobile crisis rapid response team.*" The search result yielded four additional documents, but none were relevant to the study (one news document pertained to Health Quality and Safety Medals, and although

MCRRT was mentioned as an award recipient, no additional insights relevant to this study were included in the release).

As shown in Table 1, a total of 36 documents were included in the analysis: major reports (n = 9), media sources (n = 11), and relevant internal documents, presentations, and memos (n = 16). All documents were imported into the NVivo database for data extraction and coding.

Semi-Structured Interviews

Purposeful sampling was used to identify interview participants—those individuals recognized as senior most decision-makers in conceptualizing MCCRT. Purposeful sampling is widely used in qualitative research to identify information-rich cases, when there are limited resources, includes individuals or groups who are “especially knowledgeable about or experienced with a phenomenon of interest” (Palinkas et al., 2015, p. 2). The process of identifying interview participants initially began through informal information gathering between 2015 and 2016. AT connected with a crisis response Director of services to inquire about completing research about crisis response teams. AT was informed that an innovative program was implemented in Hamilton, Ontario (the MCRRT) and was invited to attend and observe a series of presentations about MCRRT.

While attending meetings and presentations, AT asked, informally, questions about who developed the MCCRT. AT was initially introduced to the key individual who conceived of the MCRRT. From there, AT was introduced to the key players in the process of developing and adopting the MCRRT, which, in this study, are senior-most decision-makers. As such, our sample also reflects information-oriented selection in case studies which are used to “maximize the utility of information from small samples and single cases” (Flyvberg, 2006, p. 230). We reached saturation when, during the interview process, when no new information from the

themes was identified (Creswell, 2013). Five prospective individuals were identified and these five participated in the interviews. AT made attempts to identify additional decision-makers in each interview during which participants were asked to identify other key decision-makers in developing and adopting MCRRT.

We recruited participants by emailing an invitational letter with an attached information about the study and a consent to participate form. Informed consent was obtained for all interviews, which were audio-recorded with participant permission. Interviews were conducted in person (n = 1) and via Skype (n = 4); the latter occurred during the COVID-19 pandemic. AT conducted semi-structured interviews which followed an interview guide developed by AT in consultation with the co-authors and which was organized around questions pertaining to the domains of agenda setting (Kingdon, 2003) and the 3i+E framework (Gauvin, 2014). For example, participants were asked to discuss what prompted the development of MCRRT (problem definition). The audio-recordings were then transcribed verbatim and uploaded into NVivo. All direct quotes in this paper have been anonymized.

Data Analysis

Data analysis was guided by two theoretical frameworks: Kingdon's (2003) agenda setting framework, pertaining to government agenda setting, and the 3i+E framework (Gauvin, 2014), pertaining to policy development. First, all data (documents and interviews) were uploaded to NVivo. AT organized according to the two theoretical frameworks then according to the three streams of influence in agenda setting and each of the 'i's' and 'E' in the 3i+E. AT then identified themes in each category and kept notes about additional themes, for example, a common theme in problem definition that AT identified was time spent in the ED by police.

Agenda Setting Framework

Kingdon's agenda setting framework (Kingdon, 2003) was used to understand why key decision-makers from police, health, and mental health decided to prioritize a decision to change responses to PIC. As themes were sorted and refined during the analysis, the complementary factors of the 3i+E framework (Gauvin, 2014) were used to provide insight into (a) the range of factors influencing the policy choice and (b) why that policy choice was made (e.g., instead of maintaining the status quo or choosing other available options).

Kingdon's agenda setting framework (Kingdon, 2003) focuses on how issues come to the attention of decision-makers to get onto the government's agenda. The government's agenda consists of the governmental agenda, which is the larger list of issues getting attention, and the smaller decision agenda, which is the prioritized set of issues that are up for active decision-making (Kingdon, 2003). Within the agenda-setting process, there are three streams of influence: problems, policies, and politics. In the problem stream, conditions come to be defined as problems for which action needs to be taken. Attention to problems can be driven by focusing events, a change in an indicator, or feedback from the operation of current programs (Kingdon, 2003). Policies that garner attention for consideration are identified through diffusion of ideas (i.e., combination and refinement of ideas over time), feedback from the current operation of policies and programs and/or through communication and persuasion from participants in the agenda setting process. Politics also drive attention to issues through events within government, such as elections and/or changes in political party, swings in national mood, and the media (Kingdon, 2003). These streams operate independently of one another, and the governmental agenda is influenced by developments in either the problems or politics stream, and by visible participants, such as politicians, interest group leaders or journalists. An item makes it onto the

decision agenda when coupling of all three streams occurs, which is typically facilitated by a policy entrepreneur who is able to influence each of the streams.

3i+E Framework

The 3i+E framework is an analytical approach that focuses on the role of institutions, interests, and ideas as the main explanatory factors to understand their influences on policy choices (Gauvin, 2014). Institutions refer to the "rules of the game"; that is, the formal and informal rules that shape political behaviour. Within institutions there are three types of factors of influence. The first factor is government structures, which refer to the political arrangements of countries and the mandates and mechanisms that foster accountability between government and agencies. The second factor is policy networks, consisting of actors outside of the formal government process, such as key stakeholders and/or executive committees. The third factor, policy legacies, shape and limit policy development and choice based on past policy decisions. Once a policy is put in place, it shapes the course of subsequent policy-making including feasibility in the future by creating resources for policy administration and incentives for interest groups and the public. Learning effects also shape how those involved in policy discourse learn from existing policy, which makes reversing or undoing a policy very costly.

Interests can be understood in two ways. First, interests can include various stakeholders who organize around a specific policy issue, such as societal interest groups, elected officials, public servants, and researchers. Interest groups can organize for various issues such as financial or political gain or around ideas that that align with their interests. Second, interests can be framed by the way they fit within the logic of how institutions operate (Alford, 1972). Ideas consist of knowledge or beliefs about what is happening and draw on research knowledge based on evidence, expert opinion, and the experiential knowledge of interest groups. Values, or beliefs

about what ought to be, also inform ideas and shape how actors perceive and frame problems and what they view as effective, feasible, and acceptable policy options. Last, external factors operate independently of the 3i's but have an impact on the immediate policymaking community, often as a trigger to taking action to change how things are currently done. External factors include major reports (e.g., commission inquiries), political change (e.g., an election), or tragedies stemming from encounters between police and people with mental health issues (Lazar et al., 2013).

Steps to Ensure Rigor

Recognizing that this is a single case study with a small number of participants, we took various steps to ensure rigor throughout the research process. First, we used triangulation, the process of increasing the credibility of research findings (Denzin, 1970; Noble & Heale, 2019), by combining theories to interpret a phenomenon and using multiple sources. In this study, we drew on the explanatory frameworks of agenda setting (Kingdon, 2003) and 3i+E (Gauvin, 2014) to explain the phenomenon and included additional concepts from network theory and structural interests (Alford, 1972) to obtain further insight into our findings. In addition, we engaged key decision-makers from policing and health sectors to gain insight. Although there were few key individuals involved in decision-making about MCRRT, the small number of participants we engaged operate from different institutions which meant they were able to provide broad and balanced perspectives and insights about MCRRT. In addition to interviews, we drew on key internal documents for our analysis to confirm information we heard from interview participants. We also reviewed major reports to cross-reference themes. Collectively, these steps provide construct validity to our study through the use of multiple sources of evidence (Yin, 2009).

Second, Using Kingdon (2003) and 3i+E (Gauvin, 2014) frameworks as an analytical guide, we used the patterns identified in the interviews and documents to compare against the patterns predicted by the guiding frameworks, a type of 'pattern matching' used to build internal validity (Yin, 2009). As previously mentioned, we analyzed each data source separately using NVivo software by identifying themes in each data sources followed by organizing them according to the framework. Raw data was reviewed multiple times to ensure that a rich understanding of the case was developed. One limitation to internal validity in this study is that rival explanations could not be tested given the small sample size. For example, individuals in other positions of authority in and outside of the organizations could provide, for example, a different explanation of the problem. Given that it was identified that the process of developing and adopting MCRRT involved a select number of individuals in key positions of authority, we explored this further in study 3 (chapter 4) as a type of rival account of the story.

A third step to ensure rigor was to ensure detailed documentation of notes and reflections throughout the study. This included AT taking detailed field notes during and after each interview to ensure that key findings and insights were documented. Moreover, AT also kept personal notes to track personal thoughts and 'reactions' to the data. We also used direct quotes from participants to demonstrate their perspectives in our findings and insights we present in the analysis. The internal documents to which AT was granted access also aided in building a chain of evidence for our analysis. This allowed for the ability to check internal documents with broader reports and also cross-reference for similarities and differences between them and the interviews. Of course, we are aware that other sources of information were not provided, such as internal e-mails which may provide additional accounts of the process, but such documentation is rarely available for research studies such as this. However, some of the internal documents that

we were given access to provide insight into how MCRRT was positioned as the model of choice to the public.

Last, recognizing the level of access that AT was granted and previous work in the field, AT had an external resource as a type of self-checking mechanism to ensure that she was not 'going native' (Malinowski, 1922). This was a step that AT took on herself based on reflexive practice, awareness and recognition of potential ethical dillemas, a knowledge AT gained through work experience and education (MSW and Criminology particularly). Taking this step is one way to establish researcher credibility (trustworthiness and also referred to as intellectual rigor) (Patton, 1999). Additionally, AT also regularly connected with co-author and PhD supervisor MGW during the theme development, organization and analysis stages to discuss findings.

Results

Results are presented according to agenda setting and policy choice. The first section covers the factors that contributed to agenda setting, including the problems, policies, politics, participants, and policy entrepreneurs (see Tables 2 and 3).

Factors That Contributed to Agenda Setting

Problems

The problem came to the attention of key decision-makers from Hamilton Police Service and SJHH through changes in key indicators including ED volumes for individuals in crisis, police apprehension and transport to the ED, and time spent in the ED by uniform police officers (Internal communication, 2012a, 2014a, 2014c, 2015b, 2016a), and through feedback from operation of existing programs, such as COAST being unable to meet the demand of calls requiring 911 immediate response (Internal communication, 2012a, 2014a, 2014c, 2016a).

In the summer of 2013, the Joint Police to Hospital Quality Transitions Working Group, which included stakeholders from Hamilton Police Service and St. Joseph's Healthcare Hamilton, found that 66% of individuals brought to the ED by police were assessed to be low risk on the patient transfer protocol that had been established a year earlier (Internal Commumication, 2013; Internal communication, 2012b, 2016a). This finding raised the question from one interview participant: "Why are so many individuals who are considered low risk being brought to the emergency department when in crisis? . . . What other way can we provide mental health assessment and support for those calling 911?" (P2). Furthermore, it was found that uniformed patrol officers, who transport PIC to the ED, were waiting on average 240 minutes in the ED for those individuals to be assessed (Internal communication, 2012a, 2014a, 2014b, 2014c, 2016a). A focusing event, in the form of an image of several police cruisers parked outside of the ED, came to represent the two overarching problems: the volume of PIC presenting in the ED, and the rise in apprehension rates by police in response to 911 mental health calls. In fact, "about 87% of the time they [PIC] were apprehended [and brought to the ED by police]" (Internal communication, 2014c, pp. 4-6).

The inability of current programs to meet demand was also a key contributor to the problem. For example, one interview participant highlighted that "COAST could not respond to all calls, so what was happening is police responding to a variety of mental health calls just because we did not have the resources to actually respond to the calls that came into 911" (P5). Reasons for COAST being unable to respond included urgent, emergency crisis situations requiring rapid mobilization, or an inability for the crisis team to mobilize if they were busy with other calls and visits. Other reasons identified for why mental health related calls to Hamilton Police Service did not result in COAST intervention included lack of officer experience and lack

of skills in de-escalation. As a result, people with mental health concerns were apprehended under the Mental Health Act, and calls were directed back to uniform officers (Internal communication, 2012a, 2014c, 2016a).

Policies

In its initial development, the concept of the MCRRT model began through diffusion of ideas, communication, and persuasion, with later support from feedback from a pilot of its use. The idea stemmed from a recognition that COAST was already successful in the community but required changes to address the challenges outlined above. Discussions about potential solutions therefore focused on drawing upon this concept but broadening it to address the 911 response. According to an interview participant, P4,

> We started getting together to talk about how can we provide a different level of service or how can we integrate our services to provide support for people. . . . How can we get the concept of COAST, social workers, [and] police officers working together? How can we get the concept of COAST on site immediately? So that's when [MCRRT] came to discussion. We basically put our heads together to work through the challenges of getting a mental health trained social worker into a police car with a police officer.

Through informal meetings and conversations, ideas began to float, resulting in the initial MCRRT pilot. Another participant noted that: "It came out of this idea. It was, 'Just let's try it.' And somehow it made sense" (P1). The MCRRT model rose to prominence as a viable solution for implementation through feedback in the pilot phase, which established a proof of concept. The MCRRT pilot resulted in reductions in (a) officer time that would have been spent in the ED; (b) the number Mental Health Act apprehension escorts to hospital, due to the ability of the mental health professional to assess a PIC in the field; and (c) waiting times at the hospital for individuals who were apprehended (Fahim et al., 2016; Internal communication, 2012a, 2014a, 2014b, 2014c, 2016a; Younger et al., 2016). As a result of the successful pilot, MCRRT was

embraced by leadership of all three areas (police, mental health support and healthcare), and which translated into a successful funding proposal and full implementation.

Politics

The main influence in the politics stream was the lack of organized opposition in both the pilot phase of the MCRRT, in 2013, and during the formal launch of the program in 2015. As P2 commented, “I would say this was not on the radar of the [local] politicians and the bureaucrats in the sense that when we started, it was almost a little bit of an ask for forgiveness and not permission model.” Long-standing [local] interest group partnerships and collaborations contributed to the credibility of established networks (Internal communication, 2013a, 2014c, 2016a). An additional political influence, although one not directly raised by interviewees, was a heightened focus, particularly from 2014 onward, on how policy authorities (at the local level) were addressing interactions between police and people with mental health issues in crisis (Clairmont, 2014a, 2015a, 2015b, 2016; Elliott, 2014). Results from newspaper searches show that between 2013 and 2015, public scrutiny increased following several high-profile shootings, resulting in street protests, public outcry, and accusations of police brutality (Clairmont, 2014a, 2014b; Elliott, 2014). This contributed to making any actions to address the challenge politically acceptable.

Policy Entrepreneurs

In addition to the factors outlined in the three streams, policy entrepreneurs played a vital role in securing support for the MCRRT pilot and moving the funding of MCRRT onto the decision agenda. Policy entrepreneurs invest their resources into initiatives that align with their policy goals, draw attention to problems, and advocate for solutions to those problems. Individuals in positions of authority from policing, health, and mental health mobilized to pilot

MCRRT and demonstrate its impacts prior to and at the time of submitting funding for formal adoption of the initiative. Our analysis points to two pivotal policy entrepreneurs at that time, which were (former) Hamilton Police Chief Glenn DeCaire and (former) COAST Manager Terry McGurk who also founded COAST in Hamilton (Clairmont, 2015a). During the interviews, participants shared credit with everyone who was involved with MCRRT; however, these two individuals were repeatedly identified as being central to conceptualizing the initial idea of MCRRT and incentivizing other key individuals to engage in the initiative.

In summary, MCRRT gained prominence on the decision agenda due to (a) the appearance of a compelling problem; (b) a viable policy option; (c) a lack of organized opposition in the political stream; and (d) supportive visible participants and policy entrepreneurs. When the window of opportunity opened, key interests in policing, health, and mental health were able to quickly mobilize to submit applications to the Hamilton Niagara Haldimand Brant health network and secure funding for the MCRRT.

Factors Influencing the Decision to Adopt MCRRT (3i+E)

Institutions

Our findings show that MCRRT was adopted because key decision-makers strategically aligned their proposal within existing structures in ways that incrementally build on these processes without drastically altering them. The legacy of deinstitutionalization was cited as a primary institutional factor insofar as it reflects “the symptom of a lack of infrastructure for supporting people in the community” (P2). In their analysis of policy legacies of mental health service delivery in Ontario, Mulvale et al. (2007) found that both psychiatric hospital policy and Medicare contributed to a lack of resources and incentives, such that community care and services remained fragmented and failed to achieve community-based care. Findings in our study

echo those of Mulvale et al. (2007). According to participant 2 "providing care in the community around the board table sounds wonderful. But when you put it into practice, how does the person receive care? That's where…we still have a gap".

Despite the goals of deinstitutionalization, people with mental health concerns exceeded the capacity of existing programs such as COAST to meet the demand. As such, building on the already-successful COAST model facilitated the adoption of MCRRT. Our participants indicate that MCRRT was built from the existing COAST model but modified to include the 911 component: "we built off of COAST. And the challenge was in COAST, it wasn't a 911 component…an emergency response. So, building on the concepts of COAST was the biggest component" (P4). Another participant stated:

> They already had an MOU with [Hamilton] police for the COAST model and the other was the MOU that we created, [the] police to hospital transition…those were… structures that created a shared accountability. COAST one was a shared financial agreement, so we already had a history…and…the mechanisms of that. The transition toolkit got to the accountability for approaching change in a collaborative way, creating a structure to work towards effective change...based on those 2 existing structures it did help MCRRT come to life, probably a bit quicker in Hamilton (P2).

Our findings also show that MCRRT was adopted because it reflects the incremental changes to improving system coordination between police and health, the two main umbrellas of access for those in crisis. According to Pierson (1993) when institutional policies change, they do so incrementally. Our findings show that adoption of MCRRT was not a dramatic change from the already-existing resources and capacities. Having COAST in place as a secondary response, as well as a memorandum of understanding between police and mental health response provided existing administrative structures to move forward with a formalized partnership for MCRRT. Also, structural arrangements were already in place to provide mental health response because COAST was a "…hospital governed system. So governed means the funding flows through them" (P2). Whereas in other communities that rely on community based funding and

arrangement structures, MCRRT did impede existing funding arrangements, but attempted to fix gaps. Specifically, one participant stated that:

> We needed to have some kind of structure where the hospital [and] police services were working collaboratively to work through any logistical problems, any errors, any issues that happened in a real-time way…then through an MOU on what the process should look like (P4).

Lastly, the proof of concept of MCRRT laid the groundwork for the structures and processes needed to fully implement MCRRT and, as highlighted in the ideas section below, the initiative also demonstrated that it was cost-effective, reduced ED overuse, and relieved officers to tend to other calls (Elliott, 2014; Fahim et al., 2016; Internal communication, 2013a, 2014b, 2014c, 2016a, 2016b; OpHardt, 2016; Younger et al., 2016). The proof of concept showed that administrative structures needed for MCRRT did not have to dramatically alter what was already in place, making it a viable pathway forward administratively. Furthermore, by aligning the police, health and mental health focus on diversion from EDs and the CJS, the proof of concept of MCRRT provided evidence that it was well positioned to have an impact on the problem faced. Specifically, it capitalized on the policy direction of increased collaboration among agencies, systems, and services to develop new transfer protocols, and it streamlined the process of transferring care to ED staff. This latter aspect further aligned with the Ministry of Health and Long-Term Care (MOHLTC) initiative of "right care, right time, right environment" (Ministry of Health and Long-Term Care, 2011, 2015), and MCRRT further included the notion of "right people."

The decision to adopt MCRRT also meant only a minimal shift in the rules of the game for 911crisis response, transfer of care protocols, and cross-sectoral arrangements which required formalization through an MOU (Internal Commumication, 2013; Internal communication, 2012b, 2013a). First, traditionally, 911 mental health crisis response has been solely a police role

but as secondary responders, mental health professionals also respond to crises. As such, MCRRT was not a drastic change in placing a mental health professional in a police vehicle. Second, a transfer protocol between the hospital and police service was required for when MCRRT brought an individual to the hospital for psychiatric care. This shifted the decision-making power between MCRRT and the ED staff. Previously, apprehensions under the Mental Health Act required police to wait in the ED until they received clearance from the hospital team to leave, whereas with the MCRRT model, transfer of care can occur without waiting in the ED. Again, this did not change the arrangement between police and ED in transfer of care, but instead just the procedure which ultimately was viewed as being beneficial to the police and contributing to reducing costs to both systems. Third, an MOU clarified each system's commitments and responsibilities which build on already-existing accountability practices (Internal Commumication, 2013; Internal communication, 2012b).

Interests

Strong interest group mobilization was also foundational to the adoption of MCRRT. Consistent with incremental decision-making and path dependence, MCRRT provided a way to address the problem that did not conflict with powerful interests. Alford's (1972) model of structural interests helps inform why MCRRT was adopted. This model outlines three categories of structural interests: dominant structural interests, challenging structural interests, and repressed structural interests. Dominant structural interests tend to uphold the existing economic, political, and social institutions and arrangements and have the authority to shape the rules of the game (Alford 1972). Challenging structural interests reflect the pressures on existing systems that contribute to shifts in structure. Repressed structural interests are those which will not be served by social or political institutions "unless extraordinary political energies are mobilised"

(Alford, 1972, p. 14). We found that MCRRT fits within dominant structural interests, is aligned with challenging structural interests by enhancing system coordination, cost-effectiveness, and important outcomes, and did not experience interest group opposition even in the presence of non-police crisis response alternatives.

Regarding dominant structural interests, our findings show that the key individuals who developed MCRRT occupied executive positions of authority within their respective organizations. Additionally, a long-standing relationship between health and policing enabled executives in policing, health and the LHIN to call each other and discuss issues and solutions. One respondent stated:

> There was a collaborative relationship between various hospital leaders and their corresponding city and agency colleagues. One could pick up the phone and say “we need your help” and the other would say “yes, OK let’s see what’s possible (P3).

Dominant structural interests further explain the monopoly over crisis response was already secured within police and health systems through formalized agreements between police and health as a result of the COAST program. This did not alter the structure of these interests. COAST was already embedded within SJHH and with Hamilton Police Service which meant that when:

> Police came to St. Joes to ask us to, if there is something we can do to help reduce police wait times, we took that very seriously as a partner and we worked collaboratively with them, and it was a good collaborative effort (P1).

Instead, it re-aligned them through MCRRT because of the opportunity to collaborate within current operating systems, partnerships, and resources:

> It seems that there was no resistance to this, and it sounds like it was an opportunity to challenge some of the past legislation of police being the only ones that ride in a vehicle and that 911, because that reshapes and restructures mental health in policing and health care support in policing. That really opened that door for bridging that relationship (P1).

Challenging structural interests in this study reflect the system-level pressures on police and health systems regarding PIC and not specific interest groups. Challenging interests are concerned with "the cost-effective use of resources, standardisation, predictability, regulation, audit, and control" (Williamson, 2008, p. 512). Although Alford's perspective is that challenging interests operate in conflict with dominant structural interests, in the case of MCRRT, these interests aligned due to constraints on both the ED and police, resulting in an agreement to collaborate while also preserving each system's status quo. According to Participant 4 "I met with [another executive] several times, explained…what the concept of [MCRRT] was…what the impact was potentially in savings to the medical professions, the hospitals, decrease in wait times, decrease in the tying up of the paramedics".

Our data also shows that there was no opposition from organized interests, and even when opposition did occur, such as the Black Lives Matter movement, they did not impede the decision to fund the MCRRT (Alford, 1972). In fact, attention to the problem of police shootings of PIC was leveraged to substantiate the need to add a mental health responder as part of 911 police response. Alford's concept of repressed interests also offers compelling insights. Between the pilot and adoption of MCRRT, tragedies involving shootings of PIC including PIC who are Black Indigenous People of Colour, for example, the shooting of Sammy Yatim (The Canadian Press, 2013) and also movements such as Black Lives Matter occurred (Oyeniran, 2020). Adding a mental health professional to 911 police response was viewed as an alternative to police-only models. When asked if alternative programs were considered, a participant indicated: "[w]e were always looking for other programs and other responses – there were response teams but they were never 911 emergency response teams, that never occurred" (P4).

Marginalized groups including PIC have historically experienced medicalization, institutionalization, criminalization and, in the case of Black, Indigenous, and People of Colour, institutional racism and over-representation in the criminal justice system and tragedies involving shootings by police (Ghelani, 2022). In other words, these groups have not received significant political support; therefore, making it difficult to change their material conditions, at least not without extraordinary political pressure and support (Checkland et al., 2009; Peckham & Willmott, 2011). Although their interests can organize, such as through as Black Lives Matter, their concerns exist within dominant structures. Regarding MCRRT this means mitigating interactions between police and PIC by embedding a mental health professional within policing, rather than a drastic approach of reconfiguring structural conditions. This means that experiences of PIC in interaction with police resulting in their deaths and criminalization, are actually left unaddressed. In other words, factors that contribute to an understanding of criminalization of mental illness including assumptions about PIC as risky, dangerous and a threat to safety remain silenced within MCRRT initiatives and obscured by embedding a mental health professional meanwhile police retain their legitimacy as providers of safety.

Ideas

MCRRT as a policy choice, was aligned with key values from government and other stakeholders exemplified through key reports and was able to improve outcomes that were prioritized from these values. Ideas influenced the decision to fund the MCRRT through values such as patient care, safety provision, effectiveness, and efficiency. MCRRT reflects the values of right care, right time, and right people, which were significant themes throughout the interviews. MOHLTC’s *Patients First: Action Plan for Healthcare* (Ministry of Health and Long-Term Care, 2015) aimed to transform Ontario’s health care system in four ways: access

(faster access to care), connect (coordinated and integrated care in an individual's environment), inform (education and information to ensure patients have autonomy in health decisions), and protect (protect the public health system). One participant noted that by design, MCRRT is a "right time, right place, right care model to reduce unnecessary [hospital] visits" (P2) because it enables fast access to services (via 911), bridges care providers from health and policing to deliver the service in an individual's environment and diverts individuals from the ED and the courts by connecting them to community supports.

Additionally, by focusing on diversion from ED and CJS, MCRRT reflects ideas about community care by delivering services immediately and in the person's environment. According to Participant 4, this includes "the more we can get people the care they need, the less they are reliant on the services. So, the common goal is always the [PIC] and delivering them the appropriate services that they need". MCRRT as a first responder model was considered an alternative approach (diversion from ED and CJS) that offered services on scene while also working alongside the hospital through a transfer of care protocol (Internal communication, 2012b, 2013a). This aligned with ideas from several major reports that were influential when presenting MCRRT as an alternative model. The reports were identified through a combination of key interviews and the review of internal documents:

- The Triple Aim Framework[6] (2007)
- Ontario Action Plan for Health Care (2012)
- *Mental health and criminal justice: what can we learn from liaison and diversion in the USA and Canada? (2014)*

[6] The IHI Triple Aim framework was developed by the Institute for Healthcare Improvement in Cambridge, Massachusetts (www.ihi.org).

- Police encounters with people in crisis: An independent review conducted by the Honourable Frank Iacobucci for Chief of Police William Blair, Toronto Police Service (2014)
- TEMPO Report: Police Interactions—A report towards improving interactions between police and people living with mental health problems (2014)
- Toronto Triple Inquest (2014)
- Patients First: Action Plan for Healthcare (2015)
- Taking Stock: A report on the quality of mental health and addictions services in Ontario (2015)

MCRRT was the policy approach chosen at a time when concerns regarding efficiency, partnership and patient-centered care in health required collaborative efforts including with first responder. (Ministry of Health and Long-Term Care, 2011, 2015). MCRRT embodied several of these key messages; Table 6 outlines each of the reports and their influence in policy domains (agenda setting and 3i): (a) pertaining to policing, the 2014 report from Justice Iacobucci (Chief Coroner, 2014; Iacobucci, 2015) and the 2014 Tripe Inquest (Chief Coroner, 2014) highlighted the need for crisis response teams and transfer of care protocols between police and hospitals.; (b) reports outlining police interactions with PIC addressed the need for police training in mental health; increased partnerships between police, health, and mental health services; and the evidence of secondary (co-response) police response models; (c) major reports and government directives (e.g., Ontario Action Plan for Health Care, Patients First), in the health system stressed the importance of providing care in the community and outside of the ED. For mental health, the ED had become the first point of contact for mental health services, and in emergency services, police were the first point of contact for addressing mental health crises (Brien S et al., 2015;

Coleman & Cotton, 2014; Coleman & Cotton, 2016). The message of "right care, right time, right people" became a slogan for the direction that the Ontario government aimed to guide service provision.

Ideas in the form of evidence gathered during the proof-of-concept showed promising impacts of MCRRT. The results from internal data collection by SJHH and police were provided via internal documents (Internal Communication, 2013a) and were also published in psychiatric services journal (Fahim, et al., 2016). Specifically, Fahim, et al., found that:

- as compared with a policy-only model, the implementation of MCRRT led to a 49% overall reduction in the rate at which PIC were brought to a hospital;
- among those who were taken to the hospital, the proportion of PIC discharged by an ED physician without an assessment by a psychiatrist was reduced from 53% to 20%;
- 54% of those assessed by a psychiatrist required hospital admission, which was a 29% higher rate of admission as compared to the policy-only model (underscoring that fewer PIC who didn't need to be in hospital were diverted earlier); and
- the time for police to wait in the ED were less than one hour and consistently shorter than police-only response.

These points were noted by Fahim et al. to demonstrate "that MCRRT reduces the burden on EDs and acute mental health services but ensures that this level of care remains accessible to individuals who need it most" (p. 929).

Cost-avoidance through ED visits was also calculated from 2015-2016 and showed a savings of over $700,000.00 (Internal Communication, 2016b). Also, according to Internal Communication (2016b), between November 2013 and March 2015 costs associated with police wait times were also impacted:

> Police wait times in the ED also have an associated cost to our first responder services. In the MCRRT pilot an 85% reduction in police officer hours, equivalent of three full time officers spent waiting in the ED was achieved through: reducing number of visits, 1 officer vs. 2 attending (replaced by the crisis worker) and a shorter overall turn-around time (60 minutes vs 75 minutes) due to more efficient hand-over from crisis worker to psychiatric emergency room staff.

Lastly, tacit knowledge (e.g., experience working with COAST) and research evidence (e.g., secondary response models) were identified in the interviews. It was noted that because MCRRT was a first responder model, a first of its kind in Ontario and Canada, there was no initial research evidence to validate it. In the proof-of-concept phase, data were gathered by the police and health services and were used to substantiate the model (Internal Communication, 2013b, 2014b, 2014c, 2016a, 2016b).

External Events

An external factor that played an important role in adopting the MCRRT as a policy choice were high-profile shootings by police of PIC, resulting in coroner inquests and media coverage (Chief Coroner, 2014; Coleman & Cotton, 2014; Iacobucci, 2015; Reid, 2014). The tragedies highlighted areas of concern including (a) the need for police training in mental health issues, (b) unease that police had become de facto mental health crisis responders, and (c) the realization that mobile crisis response was a necessity. A notable case that occurred in Hamilton, Ontario was the shooting of Steve Mesic by two Hamilton police officers, who at the time was in distress (Dunphy, 2015). This tragedy garnered public attention and debate about how police should deal with people with mental health issues when they are distressed. As one interviewee expressed, “In 2014, the Mesic incident happened in Hamilton, funding was available, and this incident contributed to secure the funding. [The] backdrop of tragedy had leverage in making the funding happen” (P5). These external factors signaled a type of crisis in policing and health that

required the participation of both to be addressed, and MCRRT was available to be presented as the policy solution.

Discussion

Principal Findings

This study is the first to examine why MCRRT was elevated to the top of the agenda for key decision-making at the time, and the factors contributing to adoption of MCRRT. It is also the first to gain insights from the key decision-makers who conceptualized the model and pushed it into the policy arena to be implemented. In our analysis of agenda setting, we find that a compelling problem framed by concerning indicators (increase in apprehensions of PIC by police, number of low-risk PIC presenting in the emergency department) and the shortfalls of an existing programs, MCRRT was the primary alternative considered. In the political analysis of why the MCRRT was adopted, we find that within institutions, an incremental approach was adopted by drawing on existing structures of COAST. Introducing the mental health professional in a police vehicle as part of 911 response did not disrupt existing system arrangements. Instead MCRRT 'fixed' logistical errors in current practice to streamline crisis response, benefiting police and health systems.

Next, powerful interests aligned without dramatically affecting dominant structural interests. MCRRT provided a way to address problems in both systems while avoiding conflict and resistance from powerful interests. Ideas articulated in key policy documents embodying political values around improving patient care through a more efficient, collaborative response, and diversion from ED and CJS provided the groundwork for MCRRT. Moreover, the proof-of-concept provided evidence that these ideals could be achieved as intended. This was particularly important in the context of this 'new' model and lack of evidence about the impacts of such

models. Lastly, external factors, such as high-profile shootings and major reports calling for police to implement crisis response models, made MCRRT appealing because of the first responder component. Taken together, the above factors aligned to make MCRRT the best choice to be adopted.

An interesting insight pertains to the broad category of interests. We assert that key decision-makers, by way of their positionality (holding positions of authority) and their direct involvement in developing MCRRT, had a significant impact on both the development and adoption of MCRRT. First, as a network, key individuals in policing and health organized around common problems and then around their interests. That is, directives outlined by government officials, including the MOHLTC, pertaining to the direction of health services in Ontario and high-level reviews by former Supreme Court Justice Frank Iacobucci and the Mental Health Commission of Canada regarding improving police interactions with PIC. By aligning the interests of MCRRT with dominant structural interests, MCRRT received virtually no organized interest group opposition.

Also, MCRRT constrains broader systemic changes including consideration of models of response and services that do not rely on policing. By aligning interests within dominant structures, MCRRT, reinforced existing systems within which repressed interests continue to be overlooked (Alford, 1972). Another finding of note comes from the problem stream by redefining PMI as PIC. Individuals who are increasingly in contact with police and who attend the ED are now understood as PIC, and this revised nomenclature presents insights into the structure of models of response. By defining this group of people using more 'neutral' terms, crisis response models can continue to respond to individuals with mental illness and addictions

issues while at the same time expand to the broader community: anyone can be a PIC, and therefore an array of response models can be employed.

Last, MCRRT is a good example of incrementalist policymaking (Harris, 2016). Incremental theory asserts that when considering policy alternatives, decision-makers choose from previous programs, activities, and policies and modify them such that current solutions are not considerably different from previous practices. (Harris, 2016) Rather than a radical departure, MCRRT builds upon existing structures through COAST. The first responder approach challenges the traditional police monopoly in 911 but MCRRT largely retains familiarity with established components. This highlights how seemingly radical initiatives can be adopted by enhancing existing elements.

Strengths and Limitations

This study demonstrates three primary strengths. First, to our knowledge, this is the first study that draws on insider knowledge and multiple sources to understand how MCRRT was conceptualized and why it was implemented; the use of multiple sources allows for increased confidence in the findings. Second, the use of multiple sources provides insights that a single source could not provide. Moreover, the sources represent the lenses of both health and policing, which creates an opportunity for identifying consistencies and inconsistencies. Third, the application of the agenda setting and 3i+E explanatory frameworks (Gauvin, 2014; Kingdon, 1995) provides a comprehensive analysis of what may be assumed to be a taken-for-granted policy decision while at the same time rendering areas of unproblematized concepts and practices for further inquiry.

One limitation of this study is the low number of participants ($N = 5$). However, this number is mitigated by the insights of those who participated, as they were well-positioned

individuals on the subject matter. Our goal was to connect with the individuals who conceptualized the model and who were in positions of authority to push the model onto the decision agenda; all participants met these criteria. Moreover, the use of extensive documentary analysis from multiple sources either substantiated the interviewees' answers, provided additional insight, or both. Further ways this limitation was mitigated included saturation (when no new information emerged from interviews), triangulation (the use of multiple sources), and member checking (participant review of transcripts).

A second potential limitation is that we did not interview all senior managers. Our interest was in identifying the individuals who came together to form this model: whose idea was it, and how did they push it forward? These individuals occupied executive positions. And although it is not our assumption that everyone was receptive to the model (for example, front line police officers may have been less receptive to a mental health professional responding to 911 emergency calls), the model received no opposition. MCRRT, by way of design, recruited and/or appointed front line officers who shared interest with the decision-makers in the MCRRT model, or at least felt they had to because these directives came from the highest levels.

Implications for Policy and Practice

As the MCRRT model expands throughout Ontario, we hope our research provides a documented origin (a snapshot of time) of it and the major factors that secured its rise to prominence and implementation. The strategic way key decision-makers aligned their proposals within existing government directives, such that what appears to be a major change is an incremental one, can be useful in proposing "new" initiatives that expand on the boundaries of a practice. Moreover, the strategic locating of the program within the context of structural

interests, while not a new idea, provides a useful reference for aligning ideas with selected alternative proposals.

Implications for Future Research

Future research should aim to critically explore taken-for-granted terminologies, such as PMI, and explore how they are problematic, particularly in the way they reinforce and organize services, policies, and practices. Future research should also explore the conditions under which MCRRT has been implemented in communities across Ontario and the similarities and differences across decision-making domains that occurred. Consideration should also be given to communities where the model took a long time to implement or where it was considered but not implemented. This study provides insight into the central elements of MCRRT implementation. These elements should be compared across various implementation sites, where possible, and outcome measures across the domains could be used to inform clinical practice guidelines. Finally, although our research shows the persistence of structural interests, future research in this area should examine practices of resistance (e.g., defund the police), whether and how true alternative programs have been implemented, and what their central elements are.

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Appendix A: Email Recruitment Script

Ania Theuer,
Health Policy PhD Candidate
A Study of Police, Health and Mental Health Response to People in Crisis: Examining the Hamilton Mobile Crisis Rapid Response Team (MCRRT) Model – An MCRRT Genealogy

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E-mail Subject line: McMaster Study - Hamilton Mobile Crisis Rapid Response Team (MCRRT)

Dear [insert name],

I would like to invite you to participate in a 60-90-minute telephone or in-person conversation to learn about the factors that lead key-decision makers to implement the MCRRT model in Hamilton, Ontario. You have been identified as one of the key decision makers from your sector at the time of development and implementation of MCRRT.

My study focuses on a comprehensive analysis of how MCRRT was developed and implemented and to locate it within its historical context as it has been a first-of-its-kind initiative for Ontario and involved several key individuals at the decision-making level and I am interested in receiving your input as to how and under what circumstances this model became implemented.

If you agree to the phone call or in-person conversation, please complete the attached consent form and I will proceed with arranging a date, time, and for in-person conversation, a location at your convenience.

We would like to thank you in advance for your time and consideration. After a week, we will send you a one-time follow-up reminder.

Ania Theuer
Health Policy PhD candidate
McMaster University
1280 Main Street West
Hamilton, ON L8S 4K1
[telephone number]
[email address]

Appendix B: Participant Information Sheet and Consent Form: Key Informant Interviews

PARTICIPANT INFORMATION SHEET AND CONSENT FORM:
KEY INFORMANT INTERVIEWS

Study title: Police, Health and Mental Health Response to People in Crisis: Examining the Hamilton Mobile Crisis Rapid Response Team (MCRRT) Model – An MCRRT Genealogy

Local Principal Investigator	Principal Investigator
Michael Wilson	Ania Theuer
McMaster University	McMaster University
1280 Main Street West	1280 Main Street West
Hamilton, ON L8S 4K1	Hamilton, ON L8S 4K1
[telephone number]	[telephone number]
[email address]	[email address]

You have been invited to participate in an interview to explore the factors that lead to key decision-makers implement the MCRRT model in Hamilton, Ontario. These interviews will help us understand how decision-makers from sectors of police, health and mental health came together to respond to a contemporary issue.

Why is this research being done?
To date, MCRRT, as a historical moment which took place in Hamilton, Ontario, has not been unpacked to understand the policy processes involved in decision-making and implementation of the model.

Your involvement
As a key decision-maker at the time of MCRRT implementation, you've been invited to participate in an in-person or telephone conversation to provide your perspective on the factors that lead to implementation of MCRRT. The interview will be completed with the principal investigator and will last approximately 60-90-minutes. To allow me to analyze the interview data, I will audio record the interview and later make a transcript of the call. Only principal investigator will have access to the recordings.

Confidentiality
All data collected will be kept private and confidential. A summary of our findings will be presented in a way that an individual cannot be identified. Transcripts and audio recordings will be stored on a secure hard drive, in a locked cabinet in a safe location. All data will be destroyed six years after the last publication of the study findings.

For the purposes of ensuring the proper monitoring of the research study, it is possible that a member of the Hamilton Integrated Research Ethics Board and this institution and affiliated sites may consult your research data for quality assurance purposes. However, no records which identify you by name or initials will be allowed to leave the research office. By signing this consent form, you authorize such access

Risks and benefits of participating
There are no physical risks associated with participating in this study. In asking you to think about your role and experiences as a decision-maker when MCRRT was developed and implemented you may feel that you are revealing sensitive information. Also, because you are/were a public figure, you may have spoken about MCRRT on media platforms. As a result, you may be identified by the sector to which you will be speaking and by what you may have stated in the media.

I have tried to reduce these risks by ensuring that you will not be asked questions outside of factors that lead to MCRRT being developed and implemented. Also, wherever possible I will maintain privacy of your responses and the opportunity to review any verbatim quotes prior to placing them in the report, and by reminding you that you can stop participating in this interview at any time. If you have any concerns during the interview, you can speak with the interviewer at any time.

If you agree to take part in this interview, there may or may not be any direct benefit to you, but I believe that by discussing the decision-making process from the perspective of a key individual it will benefit other decision-makers when considering this and/or similar initiatives. This may lead to changes in how key decision-makers in policing, health and mental health sectors address health and social issues. This information will also provide insights into how best to structure and organize key decision-makers within policy arenas.

Voluntarism
Your participation in the interview is voluntary. You are free to stop your participation at any time. If you decide to stop participating during the interview, we will stop the recording and will stop asking you questions, and you will be asked whether you would like us to destroy the recording of what was said so far, or if we can use that information in the study. If you decide to withdraw after the interview, but before the final report is written, you may contact the research team and specify which aspects of the data you have provided should be destroyed.

Questions
If you have questions or require more information about the study, please contact the principal investigator at [telephone number] or [email address].

This study has been reviewed by the Hamilton Integrated Research Ethics Board (HIREB). The HIREB is responsible for ensuring that participants are informed of the risks associated with the research, and that participants are free to decide if participation is right for them. If you have any questions about your rights as a research participant, please call the Office of the Chair, HIREB at 905-521-2100 ext. 42013.

CONSENT STATEMENT
Participant:
I have read the preceding information thoroughly. I have had an opportunity to ask questions and all of my questions have been answered to my satisfaction. I agree to participate in this study. I understand that I will receive a signed copy of this form.

____

NAME SIGNATURE DATE

Person obtaining consent:
I have discussed this study in detail with the participant. I believe the participant understands what is involved in this study.

____

NAME, ROLE IN STUDY SIGNATURE DATE

Appendix C: Interview Guide

- ✓ Signifies prompts.

1. Could you please describe what was happening around the time that MCRRT became the model of choice?
    - ✓ What was the nature of the problem?
    - ✓ What did that mean for (representative of agency ie. police service)?
    - ✓ Why was it important to consider a response?

2. Why did MCRRT become the model of choice?
    - ✓ What are the essential features of the MCRRT model?
        - o Why were these components considered most significant?
    - ✓ Were alternative models considered?
    - ✓ Were there any policies/models being considered or built upon?
    - ✓ Could you please describe the reasons you felt were contributing to the problem? (indicators, budget issues).
    - ✓ What areas of service does MCRRT address, if any? (gaps in service)?
    - ✓ Could you describe a moment or a window of opportunity that made MCRRT possible to receive support for implementation?
    - ✓ Was there research evidence available to support the decision to consider MCRRT as the model of choice for consideration and implementation? What was it?
    - ✓ Was it considered in the decision-making process? In what ways?
    - ✓ Could you describe the ideas that helped shape MCRRT as the model of choice?
    - ✓ Could you describe the values that helped shape MCRRT as the model of choice?
    - ✓ What influenced/motivated you/your organization and the other partners to develop and implement MCRRT?

2.A. If people in crisis was not mentioned, then: Could you please discuss PIC (where the term came from, what it means)?

- ✓ In what ways is a PIC different from emotionally disturbed person (EDP) or person with mental health issues?
- ✓ Does this distinction allow MCRRT to be the model of choice of response? In what ways?
- ✓ One of the distinguishing features of MCRRT from other models is having a police and specially trained mental health professional together in a police cruiser responding to 911 calls, what is the significance/importance of having this feature?

3. Could you discuss the key individuals or groups that brought attention to the MCRRT for implementations and their role in the process?
    - ✓ Were other groups supporting this model?
    - ✓ Was there anyone that was not consulted?
    - ✓ Why did you have an interest in developing and implementing this model?
    - ✓ How did you present the issue and the model to other partners to get them on board to implement?

4. Could you describe what contributed to the development and implementation of the MCRRT?
    - ✓ Could you identify and discuss the factors that lead to the development and implementation of MCRRT?
    - ✓ Why was MCRRT the policy choice?
    - ✓ What enabled/allowed MCRRT to be implemented?

5. Were there pre-existing policies in place that enabled MCRRT to be the model of choice?
    - ✓ If yes, what were they? If not, what organizational factors/structures enabled MCRRT to be developed and implemented?
    - ✓ Did this model replace pre-existing policies and/or organizational arrangements?

6. What motivated your agency to participate in making MCRRT happen?
    - ✓ How did you see your role in the process of facilitating these relationships?
    - ✓ What types of information/knowledge aided in development and implementation of MCRRT?
    - ✓ What contributions did your agency put toward the initiative?
    - ✓ Were other areas of your agency affected by the shift in funding?
    - ✓ How did you negotiate your/your organization's role?

7. What was the rationale/goal for development and implementation of MCRRT?
    - ✓ What was the rationale/goal for your organization becoming involved in the process?

8. What did you see as the biggest needs/issues at the time that MCRRT was considered for implementation?
    - ✓ In what ways did you feel that MCRRT would address these?
    - ✓ What was it about MCRRT that made it a policy option?
    - ✓ Could you speak to any events in and outside of the government that lead to MCRRT development and as a policy choice?
    - ✓ What were the intended effects of implementing MCRRT?

9. Could you describe your organization's role in relationship to the other organizations involved in the process of development and implementation of MCRRT?
    - ✓ Were there other factors that influenced these relationships and subsequently the development and implementation of MCRRT? If so, what were they?

Table 1: Data collection for published literature, policy documents, and media

Data source	Search terms	Documents selected for inclusion	Notes
NexisUni search of newspaper articles: The Toronto Star The Hamilton Spectator	"Mobile Crisis Rapid Response Team" AND "Hamilton"	11 of 34 documents included	Remainder of articles were opinion and/or did not address policy domains.
MEDLINE search for published literature	"Mobile Crisis Rapid Response Team" OR "MCRRT" AND "Hamilton" AND "Ontario" Publication year: 2012 to Current	Results yielded 1 article	1 additional scholarly article was included in the study because it was referenced in key internal documents. The publication did not discuss MCRRT. 1 additional scholarly document was shared with an interview participant and was included in the study. The publication mentions MCRRT.
Policy documents	Documents identified through: Key participant interviews Key internal documents	8 policy documents included	
Key internal documents	Documents identified and shared by interview participants	16 internal documents included	
Ontario Government Documents Database	"mobile crisis response team*" OR "crisis response team*" OR "mobile crisis rapid response team*"	4 documents identified	Documents were not relevant to the study.

Table 2: Factors that influence agenda setting and the decision to fund MCRRT

Factors that affect agenda setting	How these factors influenced the decision to fund MCRRT	Sources of evidence
Problems	• Rising rates of low-risk individuals presenting in the ED. • Increased volume of individuals presenting in ED that could be resolved outside of hospital. • Police wait times in the ED. • Contributed to long wait times, multiple officers waiting to be released from the ED typing up police resources which translated to time and costs. • Volume of calls to COAST. • COAST was unable to meet the demand and volume of individuals requiring crisis response. • Most PIC were calling 911 for support/response. • Rising number of PIC. • Increase in number of individuals experiencing mental health crisis in Ontario. • System coordination. • Volume of PIC calls to COAST and 911 and ED required restructuring the crisis response system in place.	KI; (Coleman & Cotton, 2016; Fahim et al., 2016; Iacobucci, 2015; Internal communication, 2013a, 2014c, 2016a; Reid, 2014; Younger et al., 2016)
Policies	• Success of secondary response models/existence of secondary models. • COAST and other secondary response models were available to draw on (credibility was established in already-existing models). • Feedback from pilot phase of MCRRT. • Decrease in police wait times in ED, fast response time, and diversion demonstrated proof of concept.	KI; (Boscarato et al., 2014; Clairmont, 2016; Coleman & Cotton, 2014; Coleman & Cotton, 2016; Elliott, 2014; Fahim et al., 2016; Iacobucci, 2015; Internal communication, 2012a, 2013a, 2013b; OpHardt, 2016; Reid, 2014; Younger et al., 2016)
Politics	• Fit with MOHLTC aim of system coordination, faster care, community response.	KI; (Berwick et al., 2008; Chief Coroner, 2014;

Factors that affect agenda setting	How these factors influenced the decision to fund MCRRT	Sources of evidence
	• Lack of organized interest group opposition; Fit with Triple Aim calls for more efficient, cost-effective care in the person's environment. • Key interests organized and aligned with government initiatives/aims which makes opposition/resistance challenging. • Public response to police shootings of people with mental illness. • Public outrage and demand for action to address police interactions with PIC was widely covered by the media.	Ministry of Health and Long-Term Care, 2011, 2015)
Participants	• Buy-in from executive individuals at Hamilton Police Service, St. Joseph's Healthcare Hamilton, and the Local Health Integration Network.	KI
Policy Entrepreneurs	• Key individuals who publicly endorsed the model and coupled all three streams together: • Former Hamilton Police Services Chief, Glenn DeCaire • Former COAST Manager, Terry McGurk	KI; (Clairmont, 2015a, 2015b, 2016)

Note. KI = key informant.

Table 3: Agenda setting domains and key quotes from participants

Factors that affect agenda setting and themes	Key themes	Excerpts from interviews
Problems	Volume of individuals in ED	"And when you really looked at the numbers, was probably more than now [after MCRRT implementation] people who are going to the emergency department who maybe didn't need to have the emergency department. We knew our Ed volumes were going up, we knew our ambulance offloads were a problem, and the police were there a lot" (P1). "The number of individuals who were low risk and coming to the emergency department through those 911 calls, yeah that would have been the problem...part of the problem was the cyclical nature of those individuals without having an intervention going into crisis again and landed in the ED again, a lot of them were repeat clients. So, it was really about [reducing] unnecessary visits to the emergency room, which was better for the emergency room, better for the client and better for the police officers" (P2). "Hospital resources at the time—wait times, patient wait times, going through the roof. So, we're occupying the emerge with mental health issues" (P4). "Well one thing we did look at was the population that was coming into hospitals that were deemed low risk and what the overlap was of the population with our existing coast model. So, we are trying to understand why did those individuals not end up getting picked up by COAST. Like how did that come to be? And at the time, the reason was the vast majority were coming through 911 calls, umm and, coast is not a 911 response" (P2). "The problem was that COAST could not respond to all calls so what was happening is police responding to a variety of mental health calls just because we did not have the resources to actually respond to the calls that came into 911" (P5). "The number of people who were apprehended, the number of people who went to emergency departments, the number of people who were discharged, the length of time they stayed there, all of those would be indicators on it" (P1).

Factors that affect agenda setting and themes	Key themes	Excerpts from interviews
Policies	Success of secondary response models	"So right people actually coming to the care of the people in crisis. It seems that there was no resistance to this, and it sounds like it was an opportunity to challenge some of the past legislation of police being the only ones that ride in a vehicle" (P1).
	Readiness for change Success of COAST model History of partnering	"We had success with secondary response models through COAST, crisis outreach and support team, where police might arrive on a scene, and they might call COAST in to help them out and serve as a secondary response" (P2). "Well, we used most of the policies from the COAST program" (P5). "I honestly think that the biggest enabler was the fact that we had a well-established relationship with the police through COAST. So, you know, I think Terry McGurk who was the manager at the time of COAST, had long thought about this idea of a first responded model and I think there was a big trusting relationship in the responsiveness and reliability and quality of staff that came out of St Josephs to COAST, so police had some trust in it. I think that we had, the chief of police at the time, Chief DeCaire was very advanced in his understanding and appreciation for co response ideas. And so, I think the ingredients really were based on relationships and success of a secondary model" (P2). "There was a readiness with the Hamilton police services wanting to increase their ability to respond to mental health calls and so there was a lot of readiness with the police service" (P5). "Success with secondary response models through COAST, crisis outreach and support team, where police might arrive on a scene, and they might call COAST in to help them out and serve as a secondary response" (P5). "For 25 years or more we have been blessed at St Joe's and in Hamilton to have had COAST. It was a visionary service model and supported by successive police and hospital leaderships." (P3). "The new model was credible because of this mutual collaboration. I think the respect between respective

Factors that affect agenda setting and themes	Key themes	Excerpts from interviews
		leaderships helped cement the partnership that lead to HRCCT, and gave the funders confidence. "Yeah we believe in this, we've done it before , we can make it work"" (P3).
Politics	Not on radar of politicians	"I would say this was not on the radar of the politicians and the bureaucrats in the sense that uhm, when we started it was almost a little bit of an ask for forgiveness and not permission model" (P2).
Window of opportunity	Perfect storm	"It was a bit of the timing was right, the funding was available, the leadership was right. There was just a whole lot the. Model makes sense, it seems. Yeah, it was that perfect storm. Storm seems negative, but all the pieces were there" (P1). "Now we had this opportunity, and because we were so integrated because we had a psychiatric hospital, you know we had two you know schedule, uhm, we had a schedule 1 hospital at St. Jo's and actually Hamilton health sciences, well the general hospital at that time. And so, we all, I started working with all these stakeholders to say can we have this agreement that once we start this program, we need to have people we can refer to, right? When we have an agreement, we can actually link people up after the crisis service" (P5). "It sounds like a key, key ingredient would have been like something in terms of relationships, 100% in terms of that. Well, it took a long time to happen with the OPP, for example, because when we tried to do it with the OPP, we couldn't get any attention" (P1).
Policy entrepreneurs		"But I think honestly if, the number one thing is, Terry McGurk has a lot of credibility with the police as far as a good partner, and they trusted that if he said we would try a model and do it, that he would do it. And if we saw the need for it, there was a need for it. I think it was just the right time and the right community members and the right chief of police at the time" (P2).

Table 4: 3i+EFactors that influence the likelihood of the decision to fund MCRRT

Factors that affect policy choice	How these factors influenced the decision to fund MCRRT	Sources of evidence
Institutions	**Policy legacies** • History of psychiatric care and deinstitutionalization created the conditions where individuals with mental health and/or addictions issues were displaced in the community without the necessary services to meet their needs. • Health system continuing to address the need to coordinate community services. **Policy networks** • Pooling of resources, coordination and partnership between police service and health service and collective interest identification and connections to promote their interests. • Cooperation, trust and support and interorganizational relations between police and health at the executive level provided the capacity to mobilize political resources, collective decision-making to address problems affecting both sectors (and community and PIC).	KI; (Granados & Knoke, 2005; Pierson, 1993; Shearer et al., 2016)
Interests	**Interest groups** • Aligning health and policing services within government directives and which align with government focus on interventions aimed at efficiency, cost-effectiveness and system coordination fit with operating principles. • MCRRT was advocated for, endorsed, and conceptualized by individuals representing key positions of authority with a voice that government was inclined to consider. • MCRRT aligned with governmental dominant interests, including addressing issues aimed at diverting individuals from ED, coordinating services, providing timely (faster; efficient) access to care in the person's environment and were cost-effective.	KI; (Alford, 1972; Berwick et al., 2008; Ministry of Health and Long-Term Care, 2011, 2015)
Ideas	**Knowledge about "'what is"** • Tacit knowledge based on experience working with COAST, history of partnering and evidence from secondary response models. • Release of guidelines from the MOHLTC encouraging faster access to care, service coordination and diversion from ED. **Values about what "ought to be"** • Ontarians experiencing mental health issues require access to appropriate services in the community but utilize the ED as the first point of contact to obtain help.	KI; (Berwick et al., 2008; Boscarato et al., 2014; Brien S et al., 2015; Chief Coroner, 2014; Coleman & Cotton, 2014; Foucault, 1988; Kitts, 2014;

Factors that affect policy choice	How these factors influenced the decision to fund MCRRT	Sources of evidence
	• Mental health workers responding alongside police provide assessment in the person's environment provide information and resources and COAST completes a follow-up; care is provided in the community unless a Mental Health Act apprehension is required. • Key recommendations from review of police practices and coroner inquests outline how police services should/need to address 911 calls for crisis including specialized mental health training and reshaping the delivery of service through partnerships with health and social/community services including developing, implementing and/or expanding availability of crisis response teams.	Ministry of Health and Long-Term Care, 2011, 2015)
External Events	**Major reports, high-profile shootings, inquests and media coverage** • Attention was drawn to the problem of police interactions with PIC and the tragic outcomes of these circumstances. • PIC was a term developed to identify individuals previously categorized as PMI and/or emotionally disturbed. This more neutral term encompasses previous categories but also incorporates classification of crisis that does not preclude a mental illness or the more stigmatizing term "disturbed." • Major reports identified the need for health and policing partnerships and the need for diverting PIC from EDs and the criminal justice system. • Media reports highlighted the concerns pertaining to police interactions with PIC, pushed the problem(s) to local, provincial, and national attention which coupled with public outrage, brought the issue to the forefront to be addressed.	KI; (Berwick et al., 2008; Brien S et al., 2015; Chief Coroner, 2014; Clairmont, 2016; Coleman & Cotton, 2014; Elliott, 2014; Iacobucci, 2015; Ministry of Health and Long-Term Care, 2011, 2015; Reid, 2014)

Table 5: 3i+E domains and key quotes from participants

Factors that affect policy choice	Key themes	Excerpts from interviews
Institutions	Path dependence	"so, one of the differences in Hamilton that was somewhat unique is that the crisis services that COAST and other crisis services were hospital, I'm going to call them hospital governed, uhm, systems. So, governed means the funding flows through them. most other communities, the crisis services actually flow through the CMHA, Canadian Mental Health Association, which are community bases structures not hospital-based structures. So, it was a bit unique in Hamilton that the hospital, the hospital had the connection" (Participant 2).
	System coordination and restructuring	"Everybody is trying to do the same thing. We just didn't have enough trust in each other to come to the tables and then. So, over a period, it took a couple of years, over a period of years, we built that rapport. By the time we put the program in place, this thing was off to the races" (P4).
	Partnership	"MCRRT pulled at least 2 agencies together, healthcare and policing, and gave them the opportunity to be more inclusive, to be more open, to be more transparent and share that information in response to a specific incident" (P4).
		"It was an opportunity to challenge some of the past legislation of police being the only ones that ride in a vehicle. And that 911, because that really reshapes and restructures mental health in policing and health care support in policing. Because a lot of the mental health responders are nurses. That really opened that door for bridging that relationship" (P1).
		"People step outside of the confines of their roles or their job descriptions, or what they're supposed to do as police, or what they're supposed to do as hospital execs, or what they're supposed to do in the LHIN [Local Health Integration Network] and what we're supposed to fund because it's confined to our role" (P1).
		"I think it was a project which showed we could work together, we could be effective, we could be cross sectoral, and it would work. We didn't have to label it as medical, it was a need and we could both contribute to the solution" (P1).

Factors that affect policy choice	Key themes	Excerpts from interviews
Interests	Service integration	"We got together and started talking—the chief, myself [individual in an executive role], the vice president at [leading agency], we started getting together to talk about how can we provide a different level of service or how can we integrate our services" (P4). "There's a lot of discussion on triple aim which was looking at population health, client experience, staff experience, cost per capita, financial sustainability of all those kinds of programs" (P5).
Ideas	Safety	"There's still individuals where there's potential harm and risk where you do need police officers as peace officers to be part of the response to help support safety where that would be an issue for that crisis worker" (P4).
	Care	"People in crisis and their families should never have to choose, for example, between healthcare or police support they should be able to find a balance where the care or assistance is provided by the right people, at the right time in the right place" (P3).
External events	High profile cases/tragedies Media coverage Recommendations to address police encounters with PIC	"That report come out and made 74 recommendations so my job at the time is to put that report into, to bring it to life. Out of a tragic death, to bring that to life" (P4). "So, these are all things that we took into consideration and then the Iacobucci report was regarding police encounters with people in crisis. That was July of 2014. So, while our pilot is going on, in the background, this is taking place as well. And our job is to make sure we take those reports, and we figure out how to put it all together. So how we continue to put it together with the rapid response team, then developed into, again I think the first of its kind in Canada" (P2). "We all recall high profile cases in other jurisdictions and, sadly, even in Hamilton, in which individuals would end up in violent confrontations or even getting shot. These individuals were often in crisis and in need of a combined approach. I was glad in Hamilton were able to build on our previous success and experience" (P3).

Factors that affect policy choice	Key themes	Excerpts from interviews
		"There [were] many nights we'd get pictures from the media around the number of police cars in the Bay ambulance at St. Joe's on Charlton, and well, [we said] well, what can we do?" (P1). "I think that after the Sammy Yatim situation in Toronto, the media attention, I think people started to recognize and of course, over time now, our recognition of mental health issues has gone up quite considerably" (P5).

Table 6: Major reports that influence agenda setting and implementation of MCRRT

Report	Influence on agenda setting and policy choice
Triple Aim (2007)	Improve quality of care in dimensions of safety, patient centeredness, timeliness, efficiency and equity
Action Plan for Health Care (2012)	Address system coordination issues and increased interactions between police and PIC through apprehension and transport to ED and overuse of ED • Focus on reducing ED wait-times and avoidable trips to the ED
Mental health and criminal justice (2014)	Need for improvement between mental health and criminal justice response to PIC through policy alternatives including models of police and mental health crisis response teams to address problem areas (increase in interactions between police and PIC)
Iacobucci report (2014)	Defines PIC and contextualizes problems arising from interactions between police and PIC and identifies potential solutions addressing them including crisis response team models, police training and system partnerships
TEMPO Report (2014)	• Addresses the scope of problem pertaining to police interactions with PIC such as lack of treatment resources and service and stigma toward PIC. • Discusses solutions through multi-agency approach to PIC
Toronto Triple Inquest (2014)	• Policy approach to PIC is to expand availability of crisis response teams and establish protocols between hospital and police when apprehending a PIC under the Mental Health Act • Media attention coupled with public outcry sparked the review how to improve interactions between police and PIC
Patients First (2015)	Focus on right care, right place was a slogan used by the MOHLTC and LHIN to act on diverting individuals from ED and signaled a reshaping of emergency mental health response in the community that aligned with these objectives
Taking Stock (2015)	Focus on solutions aimed at timely access to mental health care outside of the ED

Note. CIT = Crisis Intervention Team; LHIN = Local Health Integration Network

Chapter 4: Study 3

Preface

In this chapter, the study takes a discursive turn, where I take lessons learned from the previous two studies to think critically about CRTs. My curiosity about CRTs comes at an opportune time, as calls to defund the police are met with more funding for police to implement them. Specifically, I wanted to know why police are implicated in mental health crisis response beyond frameworks aimed at problem definition. This study applies a "what's the problem represented to be" (WPR) approach (Bacchi, 2009) to Ontario's recent policy announcement that $4 million over the next 10 years will be allocated to police to develop CRTs. I was responsible for developing the research question as well as the study design, and I completed data collection and analysis. My committee contributed to the study design, and additionally, Dr. Lauren Eisler guided the development of the research question. Dr. Ann De Shalit contributed to the study design and method as well as data analysis. I also consulted with Dr. Adrian Guta in the early stages of study design and method.

What's the Problem Represented to Be in Ontario's Expansion of Mobile Crisis Response Teams?

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Keywords: What's the problem represented to be?, WPR, MCRT, mobile crisis response team, Ontario Policy, PIC, problematization, critical policy studies

Word count: 19,149 (main text) 19,383 including tables and figures
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Abstract

As of 2022, the Ontario government is investing more than $4 million to expand mobile crisis response teams (MCRTs) by allocating funds to police to respond to mental health challenges. Drawing on a poststructural approach to policy analysis, "What's the Problem Represented to be?" we excavate problem representations within policy and policy-related texts to understand why police-based MCRTs continue to be funded. We find that embedded within these texts are discourses about risk and danger regarding individuals classified as people in crisis (PIC). Furthermore, by redefining mental health in the context of safety and highlighting it as a social issue, MCRT policy facilitates the integration of health, social, and criminal legal policies and legitimizes the involvement of police in addressing mental health concerns. MCRTs are a tool through which governing takes place, under the guise of delivering better and more attentive programs. In the process, agencies involved in MCRTs must adopt principles already embedded within risk, safety, health, and mental health discourses in how they align with the state. We find that contradictory language in government policies, which emphasize risk and protection, and police as frontline heroes, exemplify dividing practices that continually (re)present people with mental health concerns as the dangerous 'Other'. Moreover, this same language, when used in the context of stigma, demonstrates the subtleties within which structural stigma operates—through the very policies that are designed to address it. We present an alternative approach devoid of police that is human rights-based and consisting of choice, informed consent, and agency.

Introduction

According to the World Health Organization (as cited in Centre for Addiction and MentalHealth [CAMH], n.d.), mental health is the leading cause of disability worldwide, with nearly 450 million people experiencing mental illness.[7] In Canada, data indicates that one in two Canadians will experience a mental illness by age 40 (CAMH, n.d.). Provinces have developed mental health policies and direction to address this issue, as healthcare is primarily a provincial responsibility (Bartram & Lurie, 2017; Iacobucci, 2014; Mulvale et al., 2007; Nelson, 2012), yet funding for mental health continues to be a challenge (Lurie, 2014). The federal government has yet to implement its promise of a permanently funded mental health transfer "to provinces and territories to assist in expanding free, accessible mental health and substance use health services" (Canadian Mental Health Association [CMHA], 2023, para. 2), which was set to begin in 2021 with an investment of $4.5 billion over the following five years. The province of Ontario is a case in point, where "mental illness accounts for about 10 per cent of the burden of disease . . . [but] it receives just 7 per cent of health care dollars. Relative to this burden, mental health care in Ontario is underfunded by $1.5 billion" (CAMH, n.d., para. 5).

A decade ago, the Honourable Justice Frank Iacobucci (2014), in his independent review of police interactions with people in crisis, when discussing the state of mental healthcare in Ontario, indicated issues pertaining to the mental health system have contributed to police encounters between police and people in crisis (PIC). Since then, the situation has not changed as PICs continue to experience increased encounters with police, of which several have resulted in fatal shootings of PIC by police (Ghelani, 2022; Koziarski et al., 2021; Shore & Lavoie, 2019).

[7] The term "mental illness" reflects the language in CAMH documents. Although the term "people with mental health issues" may be viewed as more appropriate, "mental illness" and/or "mentally ill" continues to be used in government publications, in academic journals, and across key mental health organizations including the World Health Organization, CAMH, and the Canadian Mental Health Association.

Iacobucci's (2014) description of mental health services is equally applicable today and points out uncoordinated and inadequately funded mental health services to meet the demand and complex challenge of proactively treating mental illness (p. 82).

The persistent insufficiency in mental health spending has been attributed to various factors, among them the policy legacy of deinstitutionalization (Lurie, 2014; Mulvale et al., 2007; Nelson, 2012). Until recent decades, people experiencing mental health issues—previously termed as "people with mental illness" (PMI)—were receiving care in long-stay, state-operated psychiatric hospitals (Wood et al., 2011). However, the combination of pharmacological advancements and a shift in ideology toward community care and rehabilitation beginning in the 1980s resulted in the release of these individuals into the community (Lamb & Bachrach, 2001; Perez et al., 2003; Wood et al., 2011). Unfortunately, the outcomes of deinstitutionalization have been less than favourable for people with mental health concerns and individuals who may have benefited from community care services. Considerable numbers of individuals have been left without adequate treatment, and a lack of funds to supplement community care has created a shortage in available resources, resulting in many people with mental health issues experiencing social "drift" in the community (Lamb & Bachrach, 2001).

Within the patchwork of community care, a new generation of people with mental health issues has emerged (Lamb & Bachrach, 2001). These individuals are unable to sustain themselves in the community yet are tasked with managing their mental health within it. Many of these individuals face severe mental health and substance use issues, are homeless, have been processed through the criminal legal system, and experience recurrent mental health crises that bring them to the attention of and interaction with police (Ghelani, 2022; Koziarski et al., 2021; Shore & Lavoie, 2019). These individuals also experience stigma as it relates to mental illness

"in the forms of prejudice, stereotypes, and discrimination" (Ghelani, 2022, p. 419), which has an impact on "access to healthcare, housing and employment" (Ghelani, 2022, p. 419). Moreover, they may also experience structural stigma which we take to mean stigma that is advanced through policies aimed to address it (Hannem, 2012).[8] Drawing on Goffman's (1963) discussion of stigma and Michel Foucault's conceptualization of power, Stacey Hannem illustrates the relationships between risk discourse, stigma, and power. Accordingly, stigma is a function of power that operates at the individual level (symbolic stigma) and at the level of structure and is embedded in policy, law, and interventions (structural stigma) and the link between the two is risk (Hannem, 2012). In defining structural stigma, Hannem indicates that:

> …*structural stigma* arises out of an *awareness* of the problematic attributes of a particular group of people and is based on the intent to manage a population that is perceived, on the basis of the stigmatic attribute, to be "risky" or morally bereft. Here the symbolic meets the structural in a way that causes an inherent disadvantage to a group of people. This stigma is *structural* because the difficulties that arise from it are not so much a product of the attribute itself, or any inherent problems that arise from the condition, but of the institutional and conceptual structures that surround it. Whether or not an individual experiences symbolic and individualized stigma in interactions, he or she is marked and may be subject to a myriad of interventions, regulations, and surveillance, not on the basis of *individual* characteristics, but on the recognition that belong to a statistically "risky" group (Hannem, 2012a, p. 24).

In this study we take up the contradictory language in government policies, which emphasize risk and protection (in relation to people in crisis) and that legitimize police response in mental health intervention. Specifically, by drawing attention to the problematization of 'crisis' within which risk discourse is implicated operates, we demonstrate the subtleties within which structural stigma operates.

[8] We recognize that structural stigma also refers to the exclusion people with mental health concerns from full participation in society (see for example, Livingston, 2013). However, for the purpose of our WPR analysis we draw on the definition of structural stigma by Stacey Hannem.

On March 20, 2020, the Ontario Ministry of Health introduced The Roadmap to Wellness: A Plan to Build Ontario's Mental Health and Addictions System (the Roadmap), which was updated in May 2022 (Ontario Health, 2022). Within this policy, the government articulates its intention to address mental health and addiction challenges in the justice sector by expanding mental health crisis response teams (Ontario Health, 2022). Specifically, as of 2022, the government has indicated that it will invest "more than $4 million over two years to expand Mobile Crisis Response Teams [MCRTs]. Police services in 28 communities will receive grant funding to increase their capacity to respond to calls from individuals experiencing a mental health or addictions crisis" (Solicitor General, 2022, para. 1). MCRTs entail the embedding of mental health and addictions professionals within police mobile crisis response teams to respond to 911 mental health-related call (i.e., crisis intervention), (Solicitor General, 2022). The official justifications for expanding MCRTs within mental health policy include helping police assist people with mental health issues, improving public safety, reducing interactions with police, and improving collaboration among service providers (Ontario Health, 2022, para. 3).

On the surface, MCRTs seem to be a logical solution to current challenges around responding to calls for crisis. However, these teams are also deeply involved in the management of a particular kind of threat to the social order, thus suggesting that power dimensions are inherent in their activities. These relations of power allow for people with mental health concerns to be constituted in new ways—as new objects of knowledge, PIC, requiring new governing practices, thereby shifting the ways in which police embed themselves in the lives of "problem" populations (Foucault, 1979). Notwithstanding this rationale, a need exists to deconstruct the webs of discourse, knowledge, and institutional practices that produce the power dimensions that

are at the core of such an initiative and that allow police to continue to receive funding to expand MCRTs.

Our intention is not to judge the potential success or failure of these practices and/or initiatives. It could be argued that such initiatives, of which MCRTs are an example and undertaken in this paper, are "successful" if they can reinstate PIC into a state of self-governance while contributing to the production of these individuals, as PIC, in the first place. Likewise, it is not our intention to suggest that people experiencing mental health issues should not receive support when needed. Ample research has pointed to the effectiveness of various mental health interventions when they are implemented in the community and outside of the settings of institutionalization and criminalization (Black et al., 2022; Coles, 2021; Rice & Harris, 1997). Rather, our objective is to bring to light the social dynamics at play in legitimizing police responses to mental health issues and the nature of the processes of detection and management of populations, particularly those who are deemed as PIC.

Methodology

To undertake this analysis, we draw on Carol L. Bacchi's (2009) approach of 'What's the Problem Represented to be?' (WPR). The WPR approach to policy analysis does not presume that policies are solutions to particular problems or that problems simply exist "out there." Instead, it aims to disrupt common assumptions about the government's role in solving problems (Bacchi, 2009; Bacchi & Goodwin, 2016), and asserts that policies are actively implicated in constituting and giving shape to problems (Bacchi, 2009). In this context, and in this study, we use the term government in the conventional sense such as 'Ontario government' but we also draw on a Foucauldian understanding of government/governmentality which extends beyond its political meaning. From a Foucauldian perspective, government represents relations of power

that make it possible to think certain things and impossible to think others (Bacchi, 2023). It involves the series of tactics through which governing takes place, including:

> …the ensemble formed by institutions, procedures, analyses and reflections, calculations, and tactics that allow the exercise of this very specific, albeit very complex, power that has population as its target, political economy as its major form of knowledge, and apparatuses of security as its essential technical instrument (Foucault, 2007, p. 108 in Bacchi, 2023, p. 55).

Bacchi (2009) begins with the premise that rather than reacting to problems, governments are active in producing particular types of problems through policy. This approach to policy analysis shifts the focus from problem solving to problem questioning and tasks researchers to make problems that are implicit in public policy more explicit. Doing so reveals "the ways in which particular representations of 'problems' play a central role in how we are governed" (Bacchi, 2009, p. xi), how order is maintained, and how populations live within and abide by rules. From a poststructural perspective, the view of rules extends beyond a conventional understanding of rules as produced by institutions or the state which limits an understanding of policy analysis to an analysis of institutions (Bacchi & Goodwin, 2016). Instead, rules are understood as the mechanism through which we are governed; that is, the series of networks of professionals, technologies, agencies, and rationalities that are involved with the state in creating a population that is governable (Bacchi & Goodwin, 2016). In other words, poststructuralists view policies not as the tools of government but rather as "connected up with a particular view of government" (Bacchi, 2023, p. 26). They (policies) are a rationality of government through which the state "manages 'problems' through its 'policies'" (Bacchi, 2023, p. 56). Analyzing policy means examining the conditions under which a policy is made possible and how governing takes place (Bacchi, 2023).

Policies, then, are inherently problematizing activities: “We are governed through problematisations, rather than through policies” (Bacchi, 2009, p. xi). Problematization is a tool that opens possibility to interrogate how governing takes place (Bacchi, 2023). In analyzing policy, we move away from accepting a problem at face value and that requires a policy response and, instead, we are interested in the knowledges that are lodged within a particular representation, how they come to be understood and produced as ‘problems’ for which policy is created to address (Bacchi, 2023). Bacchi is not arguing that issues raised in policies are not real, nor is WPR concerned with “what policy makers *really* meant to do” (Goodwin, 2011, p. 172; emphasis in original); instead, the purpose is to “ascertain *representations* of the truth, rather than *the* ‘truth’” (p. 172; emphasis added). This task of interrogation, or problem questioning, is completed through the analytical application of the six interconnected questions listed below to policy discourse.

1. What is the “problem” represented to be in a specific policy [in this case, Ontario’s expansion of MCRTs]?
2. What deep-seated presuppositions or assumptions underpin this representation of the “problem”?
3. How has this representation of the “problem” come about?
4. What is left unproblematic in this problem representation? Where are the silences? Can the “problem” be thought about differently?
5. What effects are produced by this representation of the “problem”?
6. How/where has this representation of the “problem” been produced, disseminated, and defended? How has it been (or could it be) questioned, disrupted, and replaced? (Bacchi, 2009, p. xii).

Question 1 begins with the policy under interrogation to identify what is being problematized. It involves reading of text and working backwards to excavate the mechanisms through which governing takes place. By drawing on direct excerpts from the policies in question, it forms the remainder of the analysis. Question 2 looks at the conditions that enable problematizations to be understood. By identifying meanings within policy, constructions of the problem representation and the political rationality/ties and technologies, the problematizations offer insight into governing. Question 3 draws on Foucauldian genealogy to examine how the problem representation has come about. The purpose of genealogy is to examine the practices that produce the problem representation and how such practices give claim to authority of some knowledges and not others. The goal of Question 4 is to disrupt the problem representation by drawing attention to silences and considering what is unproblematized and how the problem can be thought about differently. Question 5 considers the effects of problem representation(s), including discursive effects, subjectification effects, and lived effects. Discursive effects establish the boundaries within which something can be thought about, subjectification effects concern how subjects are created (made up) through the problem representation, and lived effects are the consequences of discursive and subjectification effects on the lives of individuals. The combination of all three types of effects forms what Foucault calls dividing practices – the practices or interventions that produce governable subjects that separate groups of people from one another or within oneself. Question 6 offers insight into practices of resistance, that is, alternative ways that challenge the dominant problem representations.

Theoretical Foundations of WPR

Bacchi (2009) draws on several theoretical traditions in the WPR approach, including social constructionism, poststructuralism, feminism, and governmentality studies.

Governmentality, according to Michel Foucault (1982), is "the conduct of conduct" and involves a system of power relations consisting of actors, flows, and relations of authority that are organized to achieve certain objectives (Holmes & Gastaldo, 2002; Rose et al., 2006). It relates to the assembling of state institutions and activities responsible for shaping and managing people's behaviour to ensure that it aligns with the state's objectives but in a manner that is viewed as non-state directed (Holmes & Gastaldo, 2002; Rose et al., 2006). From a Foucauldian perspective, the state is not an institution nor fixed entity, rather, it is characterized by multiple forms of governance – it includes various practices, techniques, and discourses that influence and regulate individuals and populations (Bacchi, 2023). In a neoliberal context, techniques of government are used to create a distance between state institutions and individuals (Barry et al., 1996), reconstruct individuals as responsible selves, and "act upon them through shaping . . . their freedom" (Rose & Miller, 1992, p. 18).

Broadly speaking, we refer to neoliberal modes of governance as responsibilization strategies (governmental rationalities), engaging in the 'making up' of people through the responsibilization processes such as the "discourses and practices [that] have [re]constituted citizens as actuarial subjects" (Clarke, 2005, p. 6) capable of self-regulation. Features of regimes of responsibilization processes include: new prudentialism (responsibilization of individuals, communities for their own risks); paternalism (individuals responsible for their wellbeing and risk-taking and the web of technologies such as MCRTs that are deployed through collaboration and partnerships to address those who are unable to self-manage); technologies of agency/citizenship (responsible consumers who become targeted populations based on risk for transformative purpose – to make them active citizens); politics of community (the targeted population such as PIC and the agencies and professionals that deal with these targeted groups

for the purpose of transforming risk into active citizenship and also includes the construction of community itself) (Bacchi, 2009; Dean, 1999; De Shalit, 2021; Rose & Miller, 1992).

Through these modes of governance, the state activates partnerships and relies on their convergence of expertise to deliver services and make communities responsible for addressing mental health, crime control, and deviant behaviour. Rather than the state relinquishing its mechanisms of control, it maintains and expands them by encouraging community agencies to participate in addressing issues of concern. Responsibilization tactics and tools also enable the state to disperse its powers and deploys control not in a top-down fashion but through several layers involving community, society, and individuals (Dean, 1999). The state practice of enlisting interagency partnerships to build chains of action to reinstate individuals into society gives rise, in turn, "to the development of new forms of knowledge and expertise—about the problems of coordinated action, the costs associated with them and ways to reduce them, about technologies of situational prevention" (Garland, 2001, p. 189). In short, the deployment of responsibilization strategies creates new ways of governing and "dissolves any rigid lines of demarcation between state and civil society" (Eisler, 2007, p. 114). It allows the state to extend its authority to include all networks of powers—schools, families, experts (Rose & Miller, 1992)—that engage in "the conduct of conduct" (Garland, 1997, pp. 198–202). Thus, the state produces conditions to extend its powers by embedding itself in social relationships that merge the private and public interests for social security and wellbeing with those of agents/agencies of social control (Garland, 2001). As a result, state institutions such as the criminal legal system or mental health system do not function as the sole entity responsible for the provision of welfare to individuals. Instead, these systems work alongside other institutions of social control and share

the same objectives around provision of services aimed at producing individuals who are both willing and able to participate in society (Garland, 2001).

For Foucault (1999) power is not static nor is it held by any one person, state, or entity; instead, it is conceived as diffused and existing in all social relations between individuals, actors, and institutions, and is continually redefined and reinvented. Moreover, in contrast to understandings of power as repressive, power serves a productive function; it shapes and creates reality (Bacchi & Goodwin, 2016; Foucault, 1979). Power produces the individual (subjects) as specific kinds of individuals and includes the practices and knowledges in that production (Bacchi & Goodwin, 2016; Foucault, 1979). WPR draws on Foucauldian notions of power to uncover the processes through which we governed rather than viewing policies to address problems that 'exist' (Bacchi & Goodwin, 2016). In Foucault's (1982) conceptualization of governmentality, he considers the complex form of power relations comprised of sovereignty-discipline-government (governmentality); sovereign power is concerned with rule over territory and subjects through law and police; disciplinary power is aimed at the body through surveillance and normalization to create a productive subject; governmentality is concerned with management of populations (biopower or power over life) and adopts a "*need to know"* (Bacchi, 2009, p. 27 italics in original) about a whole range of behaviours that may impact the health of the population (Bacchi, 2009) and also includes pastoral power, comprised of the professionals who guide, support, and provide knowledge to individuals and communities (De Shalit, 2021). As David Garland (1997) explains, "This form of power constructs individuals who are capable of choice and action, shapes them as active subjects, and seeks to align their choices with the objectives of governing authority" (p. 175).

Rooted in poststructuralist and social constructionist approaches to policy analysis, WPR draws on Foucault's theories of discourse (Goodwin, 2011), at times referred to as Foucauldian discourse analysis (FDA), which takes the view of "policy *as* discourse" (Goodwin, 2011, p. 170). According to Bacchi (2023), "WPR is best described as 'an analysis of discourses' rather than as 'discourse analysis' . . . [because it] involves the study of discourses, understood as 'knowledges'" (para. 5). Analysis of discourses focuses on "analysing discourses within text" (Bacchi, 2005, p. 200), such as policy speeches, and incorporates the work of a variety of policy theorists (Bacchi, 2005). The purpose of examining policy as discourse is to excavate the ways that knowledges and power relations are produced through policies including how problems, objects, and subjects are produced (Bacchi & Goodwin, 2016; Foucault, 1980; Goodwin, 2011). Specifically, policy as discourse analysis challenges statements that are often accepted without question, disrupts them, and considers alternative ways of creating policy and practice (Goodwin, 2011). Goodwin (2011) explains that "while there is no unitary 'method' for analysing policy as discourse" (p. 171), the WPR framework is useful to guide the analysis, making it a simple approach that can be widely employed without engaging in complex theory (Bacchi, 2009; Freebody et al., 2011).

Data Collection and Analysis

Drawing on the WPR approach, we analyzed 13 documents to gain a comprehensive understanding of official government discourses on Ontario's expansion of MCRTs, the assumptions embedded within it, and its effects, and we engaged in disrupting these official accounts through alternative discourses (see Table 1 for the full list). Our task was to interrogate the problem representations within these "various forms of written, verbal and nonverbal

communication" (Goodwin, 2011, p. 171), including policy documents, reports, budgets, and announcements.

Three of our sources (see Table 1) were Government of Ontario press releases: "Ontario Expanding Mobile Crisis Services to Respond to Mental Health Emergencies" (Office of the Premier, 2020), "Ontario Expanding Mobile Crisis Response Teams" (Solicitor General, 2022), and "Ontario Investing in Mobile Crisis Response Teams" (Solicitor General, 2023). We also reviewed the government's "new" approach to the mental health and addictions system, the Roadmap (Ontario Health, 2022), released on March 3, 2020. We then worked backwards to locate the problem representations that this solution (expansion of MCRTs) produced (Bacchi, 2009; Bacchi & Goodwin, 2016). We searched the Ontario government's documents database for any related policy documents using the key search terms "MCRT*," "Mobile crisis response team*," "Mental health crisis response team*," "People in crisis," "PIC," "People with mental health issues," and "People with mental health emergencies," as well as combinations thereof. A total of 630 search results were reviewed, of which two relevant reports were included: *Police Interactions with People in Crisis and Use of Force: OIPRD Systematic Review Interim Report* (McNeilly, 2017) and *OPP Mental Health Strategy: Our People, Our Communities* (Ontario Provincial Police [OPP], 2015). Finally, a search of the grey literature turned up the Ministry of the Solicitor General's (2021a, 2021b) *Community Safety and Well-Being Planning Framework: Booklet 2—A Snapshot of Local Voices* and *Booklet 3—A Shared Commitment in Ontario* and the Human Services and Justice Coordinating Committee (HSJCC) and colleagues' (2023) *Developing Mobile Crisis Response Teams: A Framework for Ontario* (*MCRT Framework*). We also included two key documents based on knowledge of the literature pertaining to MCRTs in Ontario: *Police Encounters with People in Crisis* (Iacobucci, 2014) and *Open Minds, Healthy*

Minds: Ontario's Comprehensive Mental Health and Addictions Strategy (Ministry of Health and Long-Term Care [MOHLTC], 2011).[9]

The aim of the first question (What's the "problem" represented to be?) is to draw out the various problem representations in policies (Bacchi, 2009); in this case, pertaining to MCRTs. We present these problem representations in the findings section. Thus, our analysis begins with the consideration that "what we propose to do about something indicates what we think needs to change and hence what we think the 'problem' is" (Bacchi & Goodwin, 2016, p. 16). The remaining WPR questions are nested, as we explain below. Given that problematizations are often nested within one another (Bacchi, 2009), "every question need not always be addressed in every analysis, although it is useful to keep the full set of questions in mind" (p. 101). WPR is intended to be a flexible tool rather than a prescriptive or a restrictive methodology, so it is "possible to draw selectively upon the forms of questioning and analysis" (Bacchi & Goodwin, 2016, p. 24).

In our WPR application, we consider each question while avoiding repetition. For example, we include Question 4's "Can the 'problem' be thought about differently?" with Question 6's "How [could the problem be] questioned, disrupted, and replaced?" Similarly, Questions 3 and 6 overlap. The latter's "How/where has this representation of the 'problem' been produced?" explores the rules of formation, in which certain knowledge(s) are produced, disseminated, and legitimized through institutional and political domains (Bacchi, 2009). It encompasses our discussion of responsibilization and the policy legacy of Medicare, which we include in Question 3. For Question 6, we focus specifically on ways that the problem representation could be questioned, disrupted, and replaced.

[9] These two key documents stem from findings in study 2.

Our analysis of discourse involves an iterative and reflexive process of reviewing the data. The primary researcher began by completing multiple readings of each text and creating a codebook that was uploaded into NVivo, a qualitative data analysis software. In NVivo, codes were entered as nodes and data were distributed into each node using line by line thematic coding. Themes that arose from each source were organized according to categories of problematizations and potential themes were also tracked via field notes. The primary researcher refined the themes by identifying overlaps and merging codes, arriving at three main problematizations: 1) policing problem, 2) public safety problem, and 3) coordination problem. The primary researcher then recoded the data within one of the three major problematizations. Several more readings of the texts occurred to identify assumptions within these problem representations, effects, and silences. Finally, we considered how these "problem" representations could be disrupted and alternative ones offered.

Findings

In this section we present the findings from Question 1 ("What's the 'problem' represented to be in Ontario's expansion of MCRTs?") in three broad categories: policing problem, public safety problem, and coordination problem. Where appropriate, we combine topics and key terms, which Bacchi (2009) refers to as 'nesting'. For example, within the policing problem we nested *police support* and *people in crisis*. The public safety problem and coordination problem remain as broad categories within this study. Although they include topics and key terms that warrant further interrogation that is beyond the scope of this paper. As such, we have opted to table these key terms and concepts for future WPR analysis (Bacchi, 2009). Lastly, because WPR involves the analysis of direct excerpts from the policies in question (Bacchi, 2009), the findings section pertains to WPR question 1, what is the problem represented

to be?, in the documents. Questions 2 to 5 form our analysis and question 6 considers alternatives to the problem representations.

Policing Problem

The shifting role of police officers in mental health intervention and the need for mental health training forms part of the Government of Ontario' expansion of MCRTs and is based on the rationale that the number of situations that police respond to pertaining to mental health require police officers to be supported by those with mental health expertise. Support for police is framed within collaboration between police and mental health professionals and is presented in the funding announcement to expand MCRTs: "Ontario's police officers respond to tens of thousands of [MH] calls a year and we need to make sure they have…extra support from…[MH] workers to respond to these calls, and save lives" (Office of the Premier, 2020, para. 3). Police are now regularly drawn into these complex situations and as such are "part of the mental health system—they are the front-line workers for many of the most dangerous encounters" (Iacobucci, 2014, p. 8). We can see here that 'dangerous' is used to describe mental health situations, raising the question, 'dangerous' for who? Assumptions about risk and danger, in turn, render people, situations, and spaces governable. For example, the Solicitor General (2022) indicates these dimensions of risk are present by stating that police are being "confronted" (para. 2) by situations involving PIC, MCRTs are the solution to support police and to ensure that public safety is maintained. Premier Doug Ford further reinforces assumptions of risk and danger when responding to PIC calls by stating that MCRTs have "extra support from professional mental health workers to respond to these calls, and save lives" (as cited in Office of the Premier, 2020, para. 3). In the same documents, the premier further states that MCRT expansion is part of the government's investment into the safety of frontline workers (i.e., police). These statements

reinforce the risks and dangers police incur when responding to PIC; as Justice Iacobucci (2014) pointed out: "One of the main concerns for police…is the degree of risk posed to the front-line officers who are not required to respond to calls involving a person in crisis" (p. 75).

Police Support

To help support police, Ontario has invested in de-escalation[10] training that aims to provide front-line officers with "options for responding to people in distress" (Ontario Health, 2022, para. 1) and enlists the help and partnership of academics, clinicians, and mental health and addictions experts. Equally important is the role of collaboration between police and mental health workers, through MCRTs, in responding to PIC. As the Ministry of the Solicitor General (2021b) states, "Many of these situations, such as an individual experiencing a mental health crisis, would be more appropriately managed through a collaborative service delivery model that leverages the strengths of partners in the community" (p. 4). By expanding MCRTs throughout the province, the aim is to ensure police in collaboration with mental health professionals "can work more effectively together and stay safe while handling these types of calls" (Premier Ford, as cited in Office of the Premier, 2020, para. 3). To invest in the collaborative approach, police services, within the next two years, will receive funding to develop and/or expand MCRTs by adding mental health professionals to respond to PIC.

The MCRT Framework (HSJCC et al., 2023) positions MCRTs as part of community safety and well-being, which encourages the collaboration across sectors to identify and implement risk intervention through proactive and prevention efforts: "The Police Services Act [PSA] requires every municipality in Ontario to prepare and adopt a community safety and well-

[10] The Framework (Ontario Health, 2022) mentions "de-scalation strategies that provide frontline police officers with options for responding to people in distress" (para. 88, 92) and "de-escalation tools and training for police officers to better respond to interactions with people with mental health and addictions issues" (para. 92). The Framework does not provide a definition nor specific information about what these tools, strategies are.

being plan in consultation with police services, health, education, community services and children and youth services" (p. 65; see also Ministry of the Solicitor General, 2021b). In the case of MCRTs, the aim is to fill gaps in service, and where one exists, "the non-identifiable information collected by these teams related to risk factors and protective factors in the community may assist with informing the priorities of a municipality's community safety and well-being plan" (HSJCC et al., 2023, p. 65). These initiatives are part of Ontario's Community and Safety Well-Being Planning Framework (Solicitor General, 2021a, 2021b), which focuses on building safe, healthy communities by developing crime prevention, community safety, and wellbeing practices in Ontario.

Despite police being the funding recipients and needing support, they are also positioned as supporting mental health workers by providing safety:

> Supported by the police, crisis workers determine whether an individual in crisis should be sent to an emergency department for treatment and are equipped to provide connections to community programming and supports to address an individual's physical and mental well-being over the longer term (Solicitor General, 2022, para. 3).

Safety of police officers is also identified as requiring support from mental health professionals. One specific issue that is identified throughout the policy documents pertains to the rise in mental health calls to police, which are viewed as part of the noncriminal situations to which police respond due to their 24/7 availability (Ministry of the Solicitor General, 2021b), their expanded mental health role, and the risk that officers face involving a PIC (Iacobucci, 2014; Ontario Health, 2022; OPP, 2015). When the police role includes provision of safety (by providing support or being supported) because of a perceived threat or danger, police maintain authority over the situation (Iacobucci, 2014), thereby sidelining the mental health worker and promoting the police. Both issues play out in the MCRT Framework (HSJCC et al., 2023):

> Once police officers and crisis workers arrive on scene, their respective roles differ, despite having a common goal to assist the person experiencing a crisis. It is crucial that the crisis worker recognizes that the police officer is ultimately responsible for the direction, safety and outcome of any police call for service, including a mental health and/or addictions crisis call (p. 41).

Interestingly, while the government aims to expand resources to support PIC, with MCRTs being part of the expansion, the government also hopes to reduce PIC interactions with police: "Through this expansion of specialized resources, we are taking critical steps toward providing better supports for individuals living with mental health and addictions challenges, including supports to help reduce their interactions with police" (Tibollo, as cited in Solicitor General, 2022, para. 4).

In the police support problem representation, we begin to see contradictory language of risk, danger enmeshed with safety and with wellbeing and the range of professionals required to manage these. Moreover, we see contradictory 'supporting' language; on the one hand mental health professionals are to support police because they are viewed as best in this role, on the other hand, police have the ultimate authority. Moreover, while the intention is to reduce interactions between police and people with mental health and addictions challenges, MCRTs are being **expanded** (emphasis added)**,** with funding going to police services and police having the ultimate authority in the interactions. We also see that expansion of support includes individuals and the community. Individuals are classified in different ways (person in crisis, with mental health and addictions challenges, at-risk), and expansion to the community is rationalized language such as community safety, crime prevention and wellbeing planning.

Let us now turn to the people in crisis to examine how they are represented in policy.

People in Crisis (PIC)

Several variations of the mental health crisis problem are presented in the documents we reviewed, including "mental health emergencies" (Office of the Premier, 2020), "people who are experiencing a mental health or addictions crisis" (Solicitor General, 2023, para. 1), "vulnerable people in acute crisis situations" (Solicitor General, 2022, para. 2), and "people with severe or complex needs" (Ontario Health, 2022, paras. 1, 3). These generalized categories are understood to encompass the term "person/people in crisis." As it pertains to police involvement, the behaviour of PIC takes shape in Justice Iacobucci's (2014) report on police encounters with PIC and is adopted in other policy documents (e.g., HSJCC et al., 2023; McNeilly, 2017; Ontario Association of Chiefs of Police, 2023). In his explanation of PIC, Iacobucci (2014) explains the types of behaviour that constitute PIC:

> those whose behaviour brings them into contact with police either because of an apparent need for urgent care within the mental health system, or because they are otherwise experiencing a mental or emotional crisis involving behaviour that is sufficiently erratic, threatening or dangerous that the police are called.... The term "person in crisis" is not restricted to people with mental illness. The term gives primacy to their experience ("crisis") in the specific moment that the police are involved, without drawing conclusions or making assumptions about the specific reasons for that experience (p. 49).

The other component of PIC is the "crisis," defined in the MCRT Framework (HSJCC et al., 2023) as situational and in the context of addiction, health, and/or "abilities." These conditions are situated in the context of risk to self and/or others, and:

> …involves any situation in which a person's behaviour puts them at risk of hurting themselves or others or prevents them from being able to care for themselves or function in the community. The crisis may be related to a mental health issue, addiction, a neurodevelopmental disability, dementia, an acquired brain injury and/or any other condition that impacts the person's behaviour (p. 11).

Problems arise out of police and PIC encounters for various reasons. In some cases, the danger is said to be so great that police must use force to immediately contain or subdue the

person (Iacobucci, 2014). In others, the danger is not perceived as imminent or serious, but police fail to de-escalate the situation. Failure to de-escalate can be due to a lack of understanding of the level of risk or of how to de-escalate effectively. When responding to PIC calls, police powers are outlined in the *Ontario Mental Health Act* (1990) where, in exceptional circumstances, even if a PIC is need of care from psychiatric services, police can apprehend if the individual:

> (a) has threatened or is threatening bodily harm to himself or herself, (b) has behaved or is behaving violently towards another person, (c) has caused or is causing another person to fear bodily harm, or (d) has shown or is showing a lack of competence to care for himself or herself, and where the officer is of the opinion that the person is suffering from a mental disorder that will likely result in serious bodily harm to that person, another person, or serious physical impairment of that person (Iacobucci, 2014, p. 100).

The issue stemming from police transport to a hospital for further psychiatric care is that police must wait in the emergency department until such care can be provided (HSJCC et al., 2023). The expansion of MCRTs is intended to divert PIC from the emergency department because a mental health professional will be able to determine whether the PIC needs to be sent to the emergency department (Ontario Health, 2022; Solicitor General, 2022). The MCRT Framework (HSJCC et al., 2023) indicates that diverting from the emergency department and reducing the pressure on the healthcare system are part of the primary purpose of MCRTs:

> An "unnecessary hospital emergency department visit" refers to a situation in which an individual does not appear to represent a danger or threat to themselves or others. The individual can be safely and effectively supported in the community and would therefore not be appropriate for hospital admission under the Mental Health Act (p. 11).

Diversion of "unnecessary criminal justice system involvement" (HSJCC et al., 2023, p. 12) is also a key component, where unnecessary involvement:

> refers to a situation in which an individual is deemed unsuitable for criminal detention by police because any minor offence alleged to have been committed is due to mental health and/or addictions issues or other health-related issues. The individual would be more effectively served by the health and community services sectors than being remanded into

> police custody. This includes options such as pre-charge diversion and verbal or written warnings or cautions (p. 12).

We see the positioning of PIC as comprised of various identities – they are positioned as in need of help, assistance, guidance and resources while at the same time a danger, threat, risky and also incompetent and 'disordered'. The notion of crisis is also defined to include the individual and their behaviour, made up of the above categories, and also situations that are risky and dangerous.

Public Safety Problem

The provincial data sources we analyzed commonly position the expansion of MCRTs in relation to public safety, community safety and wellbeing, and frontline worker safety. Relatedly, responding to individuals experiencing mental health and addiction issues is positioned as a situation that poses a risk to public safety and that requires de-escalation. The initial term used is "crime prevention," associated with policing (Ministry of the Solicitor General, 2021a), but because community safety involves cross-sectoral approaches, "the provincial dialogue has been refocused" (p. 3). What sectors including police (e.g., "crime prevention"), education (e.g., "safe schools"), and health (e.g., "social determinants of health") are "all referring to, in their own way, is community safety and well-being" (Ministry of the Solicitor General, 2021a, p. 3). Pertaining to MCRT partnerships, our findings locate safety, health, and wellbeing in discourses of 'risk' and 'protection'. Mental health concerns (as well as addictions, marginalization, and vulnerability) are identified as risk factors for crime, harm, and victimization.

Solicitor General Sylvia Jones stated that "Mobile Crisis Response Teams are best positioned to respond to people experiencing a mental health or addictions crisis and to de-escalate situations that could pose a risk to public safety" (as cited in Solicitor General, 2022,

para. 2). Another document positioned PIC as “emotionally disturbed persons” (Use of Force Committee, 1998, as cited in Iacobucci, 2014, p. 69), and such a person, “whether it is by reason of mental illness, or a more transient mental or emotional crisis, ... is in anguish. The person’s crisis may manifest itself in belligerent behaviour, making it more challenging to receive help” (Iacobucci, 2014, p. 62).

According to Ministry of the Solicitor General (2021b), being risk-focused on community safety and wellbeing planning is founded on the idea that:

> It is far more effective, efficient and beneficial to an individual’s quality of life to prevent something bad from happening rather than trying to find a “cure” after the fact. For that reason, local plans should focus on risks, not incidents, and should target the circumstances, people and places that are most vulnerable to risk. . .. Risks should be identified using the experiences, information and data of community members and partners to highlight the issues that are most significant and prevalent in the community (p. 13).

MCRTs are considered to be an incident-driven (reactive), community-based response “to reduce the amount of time police officers spend dealing with calls that would be better handled by a trained mental health specialist and divert individuals experiencing a mental health crisis from emergency rooms and the criminal justice system” (Ministry of the Solicitor General, 2021a, p. 21). The government press release on the MCRT enhancement grant frames it as “part of Ontario’s Roadmap to Wellness to build Ontario’s mental health and addictions system” (Solicitor General, 2022, para. 7) and states that it “complements the government’s earlier commitments to protect people’s health and enhance mobile crisis intervention teams across the province to help build a province where all people feel safe and protected” (para. 7). Solicitor General Jones (as cited in Solicitor General, 2022) further explains in the press release that MCRTs are:

> positioned to respond to people experiencing a mental health or addictions crisis and to de-escalate situations that could pose a risk to public safety . . . At a time when police are increasingly confronted with the need to assist vulnerable people in acute crisis

> situations, this new grant program will expand their ability to deliver appropriate services and underlines our government's commitment to public safety (para. 2).

MCRTs are also positioned as providing access to support and services to help "people feel safe and protected" (Solicitor General, 2022, para. 7). Expanding access to mental health supports, the government aims "to build a justice system that supports the growth of safer communities" (Downey, as cited in Office of the Premier, 2020, para. 17). Furthermore, these partnerships (via MCRTs) are stated to be "innovative ways of keeping community safe" (Downey, as cited in Office of the Premier, 2020, para. 17) and to provide "seamless access to health, mental health, addictions, housing and employment supports" (para. 17). By improving public safety and support for PIC, the government aims to ensure that it is consistent with its priority of the "safety and well-being of all people of Ontario" (Ministry of Finance, 2020, Supporting People Facing a Mental Health Crisis section, para. 1). MCRTs, by responding to 911 calls, are the mechanism through which everyone's safety is assured while providing mental health support to PIC.

Other documents echo these sentiments, such as the OPP Mental Health Strategy (OPP, 2015), stating that MCRTs aim to "improve and enhance our commitment to public safety and individuals with mental health issues" (p. 4). The same report also mentions that "mental health consumers certainly have the right to safe transportation that minimizes interference with their rights, dignity and self-respect" and that "this right must be balanced with the need for safety of all involved" (OPP, 2015, p. 12). This position is consistent with government announcements and the Roadmap (Ontario Health, 2022), all of which emphasize the safety of frontline workers: "Expanding our mobile crisis services will help those in crisis get the mental health supports they need, while ensuring our police and their community partners can work more effectively together

and stay safe while handling these types of calls" (Premier Ford, as cited in Office of the Premier, 2020, para. 3).

Frontline worker (police and mental health professional) safety is indicated in the government investment: "Our government is investing in the safety of our dedicated women and men on the frontlines, while ensuring those in crisis have easier access to high-quality mental health supports" (Tibollo, as cited in Solicitor General, 2022, para. 4). In several documents, frontline worker safety is positioned relative to the safety of, and support for, the PIC, as well as the safety of the public: the life of a PIC is given the same value as the life of a police officer (Iacobucci, 2014; McNeilly, 2017). At the same time, while balancing these rights, one report identifies that "potentially dangerous behaviour [by a PIC] includes virtually all conduct other than immediate compliance with police commands and may lead an officer to perceive a threat when a person is exhibiting non-violent symptoms of a mental illness or crisis" (Iacobucci, 2014, p. 198). The report then lists several types of behaviour that may present as symptoms of emotional or mental crisis and for which police officers may in engage in use of force: "Ignoring the officer; repetitious questioning; aggressive verbalization; emotional venting; refusing to comply with a lawful request from an officer; ceasing all movement; invasion of personal space of the officer; adopting an aggressive stance; and hiding" (Iacobucci, 2014, p. 198).

In circumstances where MCRTs respond, the safety of the mental health professional is identified as at risk The MCRT Framework (HSJCC et al., 2023). states that "this risk could be mitigated if the crisis worker remains in the vehicle until the police partner indicates that it is safe for the worker to attend" (p. 18). Safety is also framed in terms of information sharing about the PIC, which is viewed as important to protect the wellbeing and health of MCRT partners, the "client," and the public (HSJCC et al., 2023). It also includes protective safety equipment such as

"a safety vest, body armor or uniform that identifies the crisis worker as such and carrying a radio and/or an identifying badge" (HSJCC et al., 2023, p. 32).

Again, it is important to highlight that MCRTs privilege police as ultimate decision-makers in the direction of the crisis call, including safety: "It is crucial that the crisis worker recognizes that the police officer is ultimately responsible for the direction, safety and outcome of any police call for service, including a mental health and/or addictions crisis call" (HSJCC et al., 2023, p. 41). MCRTs are also positioned as part of a broader community initiative aimed at addressing various spectrums of safety, health, and wellbeing, including crime prevention and future risk and safety planning. The MCRT Framework (HSJCC et al., 2023) outlines the role of these teams in the broader context of community safety and wellbeing, embedded within the legal requirements of the *Comprehensive Ontario Police Services Act* (2019). The MCRT Framework notes,

> Through this collaborative planning process, communities can ensure better coordination between local partners, . . . developing and implementing proactive programs and strategies that address local priority risks . . . thus alleviating long-term pressure on the criminal justice and emergency health systems. This holistic approach will help ensure that the needs of vulnerable populations are being addressed by the most appropriate providers and ultimately, save lives, enhance community well-being and prevent crime. As part of community safety and well-being planning, communities may look to implement mobile crisis response teams to fill gaps in services. . .. Where a mobile crisis response team exists, the non-identifiable information collected by these teams related to risk factors and protective factors in the community may assist with informing the priorities of a municipality's community safety and well-being plan (p. 65).

Coordination Problem

The Roadmap (Ontario Health, 2022) acknowledges that mental health and addiction services in Ontario have been fragmented and disconnected. They present barriers to access, resulting in "the inappropriate use of acute services [emergency departments]" (Ontario Health, 2022), and overrepresentation of "people with mental health and addictions challenges . . . in Ontario's justice and correctional systems" (para. 1). The government has cited fragmentation,

historical funding arrangements, and confusion navigating the mental health system as part of the problem, all of which exacerbate wait times for help, including police officer wait times in the emergency department (Ontario Health, 2022). The government aims to expand mental health across the criminal legal system, of which the expansion of MCRTs is part of "an ongoing commitment to support those that support Ontarians when they need it most" (Ontario Health, 2022, para. 2) and to work "collaboratively across all sectors to provide long-term stability to our mental health and addictions system, including our justice system" (Deputy Premier Elliot, as cited in Office of the Premier, 2020, para. 4).

The majority of documents examined for our analysis point to issues pertaining to Ontario's mental health system, calling it fragmented, inaccessible, disorganized, incomprehensive, underfunded, uncoordinated, and in need of intersectoral cooperation and coordination (Iacobucci, 2014; McNeilly, 2017; MOHLTC, 2011). These documents predate the Roadmap (Ontario Health, 2022) but echo much of what the government aims to now fix. In the review of police interactions with PIC, Justice Iacobucci (2014) points to the problem of Ontario's mental health system as contributing to the police response to PIC:

> Shortage of funding for mental health care in Ontario affects police because the police are called upon to respond when a person with a mental health issue poses a danger to self or others, commits a crime, causes a disturbance, or otherwise is in crisis (p. 74).

Inquests into police shootings of PIC point out the importance and need for formal relationships between the mental health system and police which will "allow all parties to be more informed about and better equipped to assist people suffering from mental health issues or in crisis" (McNeilly, 2017, p. 35). The MOHLTC's (2011) Open Minds, Healthy Minds report also notes that "people with or at risk of mental illness and/or addictions need more than just health services" (p. 18) and indicates that integration of services, including the criminal legal system, is necessary to provide support. The report states that "by acting together, we can

transform services so that all Ontarians have timely access to an integrated system of coordinated and effective promotion, prevention, early intervention, and community support and treatment programs" (MOHLTC, 2011, p. 4). MCRTs form a part of the collaborative approach by pairing a mental health professional with a police officer to provide support to PIC (HSJCC et al., 2023; Ministry of the Solicitor General, 2021a; OPP, 2015). Efficiency, collaboration, and partnership are presented as part of an integrated model of care (OPP, 2015) that will improve outcomes, "provide services to clients across the lifespan" (HSJCC et al., 2023, p. 29), be evidence based (HSJCC et al., 2023; MOHLTC, 2011; OPP, 2015), and "reduce the burden of mental illness" (MOHLTC, 2011, p. 7).

Part of the coordination problem is the view that police have become the default mental health service providers due to their 24/7 availability (Iacobucci, 2014; McNeilly, 2017), suggesting that this is outside of the scope of their role, and as a result, resolution requires cooperation across multiple agencies (OPP, 2015). Despite mentioning that it is beyond the police role to respond to mental health crises, the Roadmap (Ontario Health, 2022) indicates that it will be the police who will receive funding to expand MCRTs precisely because they are accessed primarily through 911 police calls (Solicitor General, 2023, 2022; Office of the Premier, 2020). The MCRT Framework (HSJCC et al., 2023) indicates that the purpose of these teams is to "help to de-escalate crisis situations at the scene, divert individuals from emergency departments whenever appropriate and support clients by connecting them to local services in the community" (p. 9).

Coordination of services is also located within health-related services, mental health, and the criminal legal sector in the context of stigma and criminalization of mental illness which the coordination of services is said to address. For example, the MOHLTC (2011) states that "better

coordination across health and other human services—such as housing, income support, employment and the justice system—will lead to better mental health" (p. 8) with expected results of reduced stigma in the workplace and public services, access to community supports and integration, and decrease in people living shelters and hospitals (MOHLTC, 2011).

Although the documents do not explicitly discuss how coordination will reduce stigma, the documents do indicate that by forming MCRTs, which involves the coordination of police, health, and mental health services, this model of service delivery is aimed at reducing the stigma of mental illness (HSJCC et al., 2023; OPP, 2015). In other words, one of the outcomes of coordination is to reduce stigma of mental illness. In the MCRT Framework (HSJCC et al., 2023), stigma is said to be addressed in police training, as is using "less stigmatizing" (p. 69) language such as "mental health issue" rather than "mental illness". The OPP mental health strategy states that when a police officer who has apprehended a PIC and waiting for a transfer of care in the ED, such delays trigger stigma of mental health (OPP, 2015). MCRTs are said to engage in destigmatizing by way of providing care in the community, that is, in the person's environment, as opposed to apprehension (HSJCC et al., 2023). Interestingly, addressing stigma in the workplace, particularly in policing, has much clearer indicators for action to address stigma. For example, the OPP mental health strategy states:

> We recognize that it will take time and effort to address the stigma associated with mental health issues and operational stress injuries (OSI). Educating and supporting our members are fundamental requirements to encourage change. Sustained effort will be needed to ensure meaningful programs that support wellness at work (OPP, 2015, p. 14).

Care in the community is enmeshed within coordination because it activates the role of frontline responders, such as MCRTs, to identify and intervene in early signs of mental health "problems" because:

> Community-based services play a critical role in identifying people with early signs and symptoms of mental health or addictions problems, and in ensuring they receive the right supports and services. . .. Identifying the early signs of mental illness or addictions and getting people help, regardless of where they turn, is critical to getting them back on track (MOHLTC, 2011, p. 14).

Lastly, in the Roadmap (Ontario Health, 2022), the coordination approach explicitly points to aligning justice system approaches to mental health, and as Minister Elliott stated in the press release, "Our government is working collaboratively across all sectors to provide long-term stability to our mental health and addictions system, including our justice system" (Office of the Premier, 2020, para. 4). MCRTs, as the mechanism to address the problem of systems coordination, aim to contribute to evidence-based crisis response models through program evaluation and various outcomes. The MCRT Framework (HSJCC et al., 2023) states that as coordination of MCRTs improves across Ontario,

> it is timely to share subject matter expertise and evidence-based best practices for the development, implementation and evaluation of these types of program models. This includes best available practices in community engagement, partnerships and stakeholder investment, program development, scope of practice, regulatory considerations, risk management, operational standards, data collection, evaluation and sustainable funding approaches (p. 12).

In the OPP's (2015) report, the collaborative approach to service delivery of policing is framed in terms of time spent responding to PIC calls and their safety:

> The aim is to ensure the OPP's response to mental health is consistent and efficient . . . Since collaborative approaches in policing service delivery are fundamental to implementation of the strategy, it makes sense to share this work as broadly as possible. Collaborating with external partners and fostering internal partnerships form the basis for an integrated model of practice (pp. 2, 4).

The involvement of multiple professionals and institutions within the coordination endeavor continue to mainly rely on policing as the source through which coordination is aimed to achieve. Locating MCRTs and coordination within community care signals a blurring of boundaries between individuals who were once institutionalized and the broader community, and

also between traditionally independent systems and professionals. The purpose of coordination appears universal to anyone who needs support, intervention, and prevention whether it be health related, mental health related and/or criminal legal related. We find that the coordination problem signals the range of responsibilities for safety and protection of everyone, whether they are a person with mental health concerns, or presenting a risk or danger, and general safety and wellbeing across the community. We also see that reducing stigma is an aim of coordination although this is not defined in the context of support, intervention, and prevention. The coordination effort to reduce stigma of mental illness appears to refer to stigma at the individual level of interaction (i.e., in police interactions with PIC). The findings seem to show that by coordinating services to include mental health professionals with police, and other services, it will lead to better outcomes during interactions with PIC. The coordination approach focuses on how stigma operates at the individual-level in interaction (symbolic stigma) but it does not address structural stigma. When speaking about stigma as it pertains to police and frontline workers more specifically, however, stigma about mental health is represented in relation to post-traumatic disorder (PTSD) and operational stress injury (OSI) – we observe these presented as outside of the individual's (police officer's) psyche. It is attributed to their job – they do not have a mental illness; instead, their job causes PTSD.

Now that we have identified the problem representations, we turn to our analysis of them by applying the remainder of Bacchi's (2009) questions. The next section applies Questions 2 to 5, and the conclusion encompasses WPR Question 6.

Discussion

In this section we draw on WPR Questions 2 to 5 (Bacchi, 2009) to identify the assumptions that are embedded within the above problematizations, their historical underpinnings, and the silences within these problem representations.

What Presuppositions or Assumptions Underpin This Representation of the "Problem"?

This question addresses the explicit and implicit assumptions embedded within the three problem representations identified in the first question. The assumptions that accompany the need for support for police are the ever-expanding role of police response to PIC and the magnitude in demand for this support, which leave police as de facto mental health workers. Due to their 24/7 availability, police have become the first responders to social disorder situations, to which mental health is a contributing factor. The three problematizations identified in Question 1, taken together, create a dominant narrative in government texts that is reinforced through the assumptions that underpin it and the conceptual logics on which it relies. Our critical analysis of discourse reveals these problematizations to be underpinned by three connected sets of assumptions: risk and danger,[11] safety, and neoliberal responsibilization.

Assumptions of Risk and Danger

Analysis of the findings regarding MCRT expansion policy is underlined by assumptions of risk and danger. Despite evidence showing that it has been PIC who have been subjected to "danger" via police shootings. For example, "between 2000 and 2020, 68 per cent of people who died in encounters with police in Canada were experiencing a mental health crisis" (Mukherjee, 2022, p. 141). We observe this shift broadly in Ontario's mandated community and safety wellbeing plans via the *Comprehensive Ontario Police Services Act* (2019) requiring

[11] We have grouped risk and danger to show how these assumptions 'link up' with governing strategies through MCRT policy.

communities to assess risk factors—of which mental health is one (Ministry of the Solicitor General, 2021a, 2021b)—and specifically in the shift to use the term PIC. Historically, "risk meant essentially the danger embodied in the mentally ill person capable of violent and unpredictable action" (Lupton, 2006, p. 94). Presently, risk is calculated through aggregate means and derived from populations rather than from individuals. At the same time, risk applies to:

> A larger group of people than the notion of dangerousness: A risk does not arise from the presence of a particular precise danger embodied in a concrete individual or group. It is the effect of a combination of abstract *factors* which render more or less probable the occurrence of undesirable modes of behaviour (Castel, 1991, p. 296).

The shift from danger to risk opens new avenues for monitoring populations, a new form of surveillance where an individual who is identified as posing a risk no longer "has to be individually observed for signs of dangerousness. It is enough that she or he is identified as a member of a 'risky population' . . . developed from calculations using demographic and other characteristics" (Lupton, 2006, p. 97). For example, we see this in the requirement of data collection about risk and protective factors in the community with PIC and as part of the overall safety and wellbeing planning (HSJCC et al., 2023; MOHLTC, 2011; Solicitor General, 2022). Because no situation is entirely risk-free, this opens the opportunity for "a potentially infinite multiplication of the possibilities for intervention" (Castel, 1991, as cited in Lupton, 2006, p. 96). Viewed this way, modern society no longer has to be managed through strategies of confinement, coercion, and incarceration. Strategies to mitigate risk to the public (Solicitor General, 2022) are predicated on avoiding environments in which potentially "risky" people may operate so that "all people feel safe and protected" (para. 7). With the expansion of MCRTs, part of the intention is to provide this service in the person's environment (be it at home, in public, or at school) instead of within formal institutions (MOHLTC, 2011; Ontario Health, 2022; Ministry

of the Solicitor General, 2021a, 2021b). At the same time, for any PIC who is "deemed to be threatening or disruptive in some way to the social order, risk calculation involves the qualitative assessment of risk for individuals and groups who are deemed to be 'at risk'" (Dean, 1997, as cited in Lupton, 2006, p. 100).

In the context of safety and wellbeing for all (Ontario Health, 2022), PIC as a category diminishes the distinction between unhealthy and unsafe since everyone is assumed to be at risk. These assumptions, then, open the space for monitoring the wellbeing and safety of individuals, situations, and populations that were previously unchartered. Moreover, this form of monitoring enables MCRTs to act as a mediator between those whose behaviour may dictate their entry into the formal system when they are unable to manage their symptoms—a form of diversion—and a manager of those who are postdiagnosis and postinsitutionalization. In this manner, social control transcends boundaries between judicial and social institutions (Foucault, 1980), and the PIC is now connected across all institutions.

MCRT professionals are tasked to manage so-called risky and dangerous individuals in the community under the threat of being held accountable for the potential harm to the general public – i.e. 'normal people'. The assumption that PIC are dangerous is inconsistent with evidence about the association of mental health with violence. According to CMHA (2011, 2019), there is a lack of evidence linking mental health and violence. In fact, evidence is to the contrary: people with mental health issues are more likely to experience violence, victimization, and stigma (Hensley, 2020), and more likely to be killed or injured by police. Despite these facts, the assumption that PICs are somehow more dangerous and riskier than other populations is perpetuated in interventionist policies.

Additionally, by using the backdrop of protecting lives and also providing public safety, MCRT as a modern strategy of governance incorporates the notion of governable spaces which has as its target risk and danger within community. The role of MCRTs is to fill gaps in service by collecting information related to risk and danger factors in a community with the purpose of enhancing community safety, protection, and wellbeing (HSJCC, et al., 2023). For example, the Ministry of the Solicitor General (2021b) emphasizes that being risk-focused within community safety and wellbeing planning is helpful in identifying experiences, information, and data of community members to measure the degree to which risk is experienced in the community. Governing through assumptions of risk enables the community to be reconfigured as a space of security and the community takes on the responsibility for risk management and surveillance. As Castel (1991) observes, interventions, such as MCRT, can be justified on the basis that undesirable behaviours that constitute crisis and, therefore, risk can exist and be managed. This reformulation provides a rationale for various techniques to be used to govern the marginal.

Underlying this narrative is the notion that individuals are responsible for their own self-management and when this self-management process is disrupted, technologies for the purpose of reinstating it are deployed. Thus, the relationship that a person has with oneself becomes the subject of reconstruction through professional intervention. However, if the person fails to reinstate themselves (i.e. self-manage), they are repositioned through what Garland (1996) refers to as a Criminology of the Other which relies on inducing fear and anxiety; these individuals are defined as dangerous members of groups and social class who require more coercive means of control (see also Hannah-Moffatt, 2000). In other words, one has the "choice" to either accommodate an intervention or potentially see their perceived level of risk or danger increase followed by further methods of intervention including apprehension.

When a PIC does accept the MCRT intervention, they are reconnected with their community. As such, community programs function under the premise that everyone who is excluded should have the opportunity to gain or regain membership within the community through adherence to "...core values of honesty and self-reliance" (Rose, 2000, p. 335). Individuals who, through intervention, become included or reinstated in community, do so by restoring self-control and self-management through self-discipline. Through these risk logics, MCRT acts as a way to ensure optimal monitoring of risky people, potential risks and the community becomes a means through which those who are deemed to pose a threat are managed.

Assumptions of Public Unsafety

Even if it is just "Other assumptions also underlie the problem representations discussed in the findings section, including assumptions of public unsafety. Here, mental health is framed through assumptions of public unsafety. These assumptions are evident in the convergence of health, social, and criminal legal policy, and the legitimization of criminal legal institutions, specifically the police, in the business of mental health. Police and mental health professional partnerships have the potential to criminalize PIC behaviour, reify police as the protectors of safety, and potentially silence the mental health worker (De Shalit et al., 2022). Through these government efforts, a melding of crime, public safety, and wellbeing begins to take shape. In the process, agencies involved in MCRT have had to adopt principles already embedded within these discourses in the manner by which they align with the state – which includes the pre-identification of potentially "unsafe" persons through early intervention; responding to those already deemed "unsafe;" and reinforcing public protection. Health and safety thus became enmeshed wherein terms such as "persons in crisis," "the mentally ill," "patient," and "consumer" come to mean one and the same.

Accordingly, the MCRT framework serves as a blueprint for defining goals, objectives, and expected outcomes as it relates to the team itself, and also with respect to public safety. The Roadmap provides information about the tools that will be utilized to apply their safety work – de-escalation training – the use of which reinforces that human activities and behaviours *should* function in such a way so as to avoid the deployment of MCRT. That is, by adhering to socially- and legally sanctioned standards of living in the community.

The MCRT framework, with its aim to improve mental health by including the justice sector within it, can borrow language from either health, social work, or criminal legal discourse to refer to unsafety. Agencies, then, in one way or another, have to integrate these discourses into their service delivery, regardless of whether they individually adhere to them. Moreover, because it is the police that receive the funding for MCRT expansion, it is also the police who continue to be viewed as providing safety and protection to people and the community, notwithstanding the experiences of PIC in interaction with police resulting in their deaths and criminalization. Furthermore, by legitimizing police as primary providers of safety, MCRT policy reifies the 911 emergency system as the primary means through which mental health and crisis, and therefore safety, are to be addressed. Even though other systems that do not involve police, such as 9-8-8 (Human Rights Watch, 2023) exist, these services are subordinated to the traditional status quo.

Providing safety and protection to PIC and the community as well as protecting the public from PIC does not address the social conditions that have given rise to individuals being in crisis in the first place—which are in fact the ultimate barriers to social inclusion, especially for marginalized individuals. Instead, people are encouraged to participate in their own subjectification—control disguised as social security and wellbeing (Foucault, 1980, 1982). Ontario's aim to provide safety, therefore, "discursively and practically [positions] the

authoritative state as only a solution" (De Shalit, 2021, p. 21) to the safety threat and not as a contributor to unsafety.

If, in the process of producing the active subject, the individual is disconnected from the conditions that give rise to their crisis in the first place, then governing strategies also blur the lines between state and society: The state continues to maintain its social control functions "as a point from which projects of government emerge and a location from which numerous private powers derive support for their activities" (Eisler, 2007, p. 114). While continuing to target its traditional clients, the criteria expands to potentially target any individual within a population through neutral categories such as "crisis," thereby creating a net-widening effect. Traditionally, marginalized populations (now encompassed under PIC) have been systematically examined, classified, and subjected to pursuing self-knowledge as a means of moral reformation to a greater extent than their counterparts, as they are viewed as posing an actual threat to public safety (Rose, 2000). Through MCRT any individual can now come to be examined by the social and criminal legal institutions that have traditionally targeted marginalized populations. This means, for example, that whether you are an individual who is diagnosed with a mental health condition or an individual who feels they need support, you are a PIC in both instances, and when MCRT responds, the same people (police, mental health practitioners) and the same tools (mental health and risk assessment) are applied.

Assumptions of Neoliberal Responsibilization

Additionally, implicated within MCRT policies are neoliberal modes of governance, wherein the state disperses its powers and deploys its control through layers of community, society, and individuals. Governing in a neoliberal society is concerned with the wellbeing of the whole population (Li, 2007) with the intent to secure "the improvement of its condition [and] the

increase of its wealth, longevity, health, et cetera" (Foucault, 1991, as cited in Li, 2007, p. 275). Improving the wellbeing (and/or safety) of populations cannot be accomplished through coercive means; rather, the state operates "by educating desires and configuring habits, aspirations and beliefs" (Li, 2007, p. 275), and people, acting in their own self-interest, "will do as they ought" (Scott, 1995, as cited in Li, 2007, p. 275). Accordingly, these practices involve expert intervention to mitigate risks and improve outcomes (i.e., in the case of MCRTs, improve outcomes for PIC).

Neoliberal responsibilization strategies are based on the premise that the state alone cannot address social issues and that the key to producing order and conformity is located within institutions of civil society (Dunleavy & Hood, 1994; Garland, 1997; Simonet, 2015). In this approach, the state takes a less direct role from that of "command and control" (Garland, 1997) to that of coordination, aligning and organizing to ensure that everyone plays their part in managing individuals. The state's role becomes that of supporting by reorganizing the provision of public services based on the principles of the market and opening up competition for resources among service providers and "activating action of non-state agencies" (Garland, 1996). Assumptions about this type of interagency cooperation and partnership are exemplified in the Roadmap (Ontario Health, 2022), the community safety and wellbeing planning framework (Ministry of the Solicitor General, 2021b), and related MCRT documents. For example, in his review of police encounters with PIC, Iacobucci (2014) states that one of the key themes in his report indicates that cooperation requires not only the involvement from police and mental health professionals but also from those accessing their services, referred to as "mental health consumer-survivors" (Iacobucci, 2014, p. 8). Viewed this way, PIC are positioned as capable of demonstrating active citizenship by taking steps to participate in better self-management. For

example, when MCRTs respond to a particular behaviour and risk is assessed, the PIC, if they "accept" the intervention and internalize it, are demonstrating their ability to self-manage. Only by actively participating in the disciplinary process will the PIC be diverted from the criminal legal system and/or the emergency department. Thus, the PIC is deemed responsible for changing their behaviour; otherwise, greater measures will be taken to ensure that they comply. In other words, if the PIC can demonstrate self-control and receptivity to the help offered, no further action will be taken to gain compliance.

The systems coordination goals presented in the findings section of this study (HSJCC et al., 2023; Ontario Health, 2022; OPP, 2015) also legitimize the development of MCRT, which is aimed at faster access to care that is as close to the individual's environment as possible (e.g., in their home or the community). The coordination effort aligns with the process of responsibilizing community organizations to provide services that are timely, accessible, and reduce costs, and which claim to hold public agencies accountable for using public funds and delivering better and more attentive programs (Aberbach & Christensen, 2005; den Heyer, 2011; Simonet, 2011). We see this in the Ontario province's focus on diversion from the emergency department and criminal legal system by activating police partnerships with health and mental health services (HSJCC et al., 2023; Ontario Health, 2022; Solicitor General, 2022). In the process, agencies involved in MCRT have had to adopt principles already embedded within risk, safety, health, and mental health discourses in how they align with the state. This includes identifying people who may have mental health issues through early intervention, responding to those already deemed to have mental health issues, and reinforcing public protection. Within the partnership and coordination problem representation, the state, by enlisting partners from police, health, and mental health systems and services, enables MCRTs to be produced and presented as a solution

to these problems. In doing so, the state participates in exercising prudence by making individuals and communities responsible for safety and wellbeing, for example, through legal obligations to produce community safety plans which are risk-focused and which position MCRTs as a response to potentially risky situations (Ministry of the Solicitor General, 2021b). Through these "partnerships in prudence" (Rose, 2000, p. 328), the linking of MCRT systems, people, and communities further reifies the state and its partners as the solution and not as part of the problem. Furthermore, our findings show that MCRTs do not remove the traditional health-legal system response to people; the Roadmap indicates that to build the criminal legal system, and address challenges in the criminal legal sector regarding mental health, includes an expansion of MCRTs (Ontario Health, 2022).

Our findings also show that by positioning the wellbeing and safety of Ontarians as the backdrop for improving people's lives and doing so in the "right manner," the MCRT policy shapes the expectations of a process that produces the prudent subject. Underlined by assumptions of neoliberal responsibilization, the prudent subject is expected to engage in a "risk-minimizing lifestyle… simultaneously [being] incited to entrepreneurial action as risk-taking is transformed into a public virtue" (Lemke, p. 2012, 50). For example, the MOHLTC (2011) document, Open Minds Healthy Minds, outlines the importance of wellbeing for enhancing physical health, improving success in school and at work, contributing to productive relationships, building self-confidence, and providing constructive ways of managing stress and negative emotions. However, when the prudent subject "fails" to engage in individual and collective responsibility for wellbeing and safety, they experience crisis, whether it be because they have a mental health concern or because they are unable to manage their behaviour, at which point the person experiencing the crisis can call 911 and MCRT can step in. In this way, a crisis subject is

produced through the MCRT response and its assumptions of neoliberal responsibilization. We take up the production of the PIC in more detail in the next section.

How Has This Representation of the "Problem" Come About?

The purpose of this question in WPR is to identify the practices and processes that contribute to the dominance of particular problematizations within current policy discourse (Bacchi, 2009). We referred to some of these processes in earlier sections, including the neoliberal responsibilization assumptions that underlie MCRT policy. In this section we examine the term "PIC" to demonstrate that the shift in language from "PMI" to "PIC" constitutes new ways through which populations are and/or can be governed. Embedded within these texts are assumptions of risk and danger that continue to frame people with mental health concerns while creating the classification of crisis, which broadens the reach of MCRTs to the community (the population) and diffuses power to wider areas of life.

The Making of PIC Subjects

Foucault's (1982) conceptualization of governmentality is informed by his work on biopower which is concerned with management of populations and the creation of productive, ordered individuals. This requires a "*need to know"* (Bacchi, 2009, p. 27 italics in original) approach about a whole range of behaviours that may impact the health of the population (Bacchi, 2009). Key components derived from acquired knowledge about people are used in shaping the policies and practices which determine how populations will be managed and monitored to ensure that compliance is achieved. Gaining compliance through the regulation of health/wellbeing and security of people and populations reflects a contradictory neoliberal paternalistic process. On the one hand an individual is regarded as responsible for their risk management and wellbeing "as individuals capable of choice and action, shapes them as active

subjects…and aligns their choices with objectives of the state" (Garland, 1997, p. 175) and at the same time relies on social control mechanisms to help them.

In the context of MCRT policy, we see a shift in terminology from "people with mental illness" or "emotionally disturbed person," where the pathology may be viewed as intrinsic to an individual, to more neutral terms such "PIC," where mental health concerns and crises are "normal" facets of daily life. PIC is viewed as a more neutral classification of individuals; crisis can be anything and happen anywhere and can include those with mental illness as well as those without, "since not all people in emotional or mental [crises] whose behaviour elicits a call to the police" (Iacobucci, 2014, pp. 48–49) will have a mental illness or an addiction issue. Whatever the crisis does entail, though, requires either self-management and/or an MCRT to help, support, and guide the individual back to a state of self-control. Implicated within this notion of neutrality is a neoliberal paternalistic discourse that conveys representations of people or groups that are capable of managing their crisis and/or mental health and able to make choices about their wellbeing. However, when individuals are unable to self-manage, paternalistic means of governing are deployed at people and populations when they are viewed "as incapable of acting in self-interest and as in need of guidance" (De Shalit, 2022, p. 45). In the process, the classification of people as PIC shapes actions that allow for new ways of knowing and acting to become possible (Fejes & Nicoll, 2008). Moreover, embedded in this knowledge are implications for the exercise of power: this exercise of power, by drawing on knowledge, will determine how actions of individuals (PICs) are presented (i.e., acceptable/unacceptable) and define individuals in ways that "allow things to be done" (Ahl, 2008, p. 151).

Reconceptualizing PMI as PIC downplays the contradictions inherent to these power relations by reinforcing the neoliberal paternalistic project that "individualizes social conditions,

and at once, maintains subjects [PIC] as responsible for their own [crisis management] [and] self-regulation and redemption" (De Shalit, 2021, p. 45). The conditions that gave rise to the crises experienced by these individuals in the first place, for example, the legacy of deinstitutionalization that did not live up to its promise of funding community services which in turn contributed to fragmented service delivery; it also includes the efforts at destigmatizing mental illness that focus on individual-level responses while failing to recognize the structural elements that contribute to reproducing it in. These unresolved, and unaddressed, contradictions make it so that the focus will continue to be on those in certain categories—PMI, the poor, homeless individuals, discharged psychiatric patients—while making room for new categories of individuals to come in. This way, the mental health subject continues to be reproduced, known and acted upon. The PIC comes to occupy the subject position reflecting neoliberal responsibilization rationalities to which MCRT responds. The PIC subject is tasked with self-management of risk and discipline (De Shalit, 2022). Thus, as Foucault (1995, as cited in Ahl, 2008) points out, "Knowledge orders people and objects . . . determines what is desirable or not . . . [and] acts as a way to privilege certain actions and relations. Knowledge produces subject identities . . . *knowledge is therefore never neutral*" (p. 151; emphasis added).

Gathering information about PICs produces knowledge about this particular population. In the context of MCRT practice, the collection of risk and protective factors (HSJCC, 2023) can become a measure of the overall population health. From a governmentality perspective, the measure of population health through statistical data allows for a construction of knowledge around a norm against which the abnormal will be measured (Foucault, 1975). Furthermore, the knowledge gained about populations of PIC will allow experts to identify groups of individuals according to particular characteristics. By classifying PICs as a "type" (e.g., serious risk versus

low risk), several options emerge: (a) MCRT actors provide an intervention that is intended to help the PIC cope (i.e., self-manage); (b) the PIC demonstrates that they have the self-knowledge to reduce the crisis and remain in the community, thereby diverting them from formal systems; or (c) formal systems are activated whereby the PIC is further observed, monitored, and treated. In each instance, by deploying the MCRT, the aim becomes to provide various avenues for the PIC to engage (or re-engage) in the production of the docile body. That is, the dispersal of power to “ever-extensive areas of social life” that spread “throughout the city” (Foucault, 1979, p. 217) and one “that may be subjected, used, transformed and improved” (1979, p. 136). In this study, we take this to mean the individual body that can be shaped or re-shaped as an active citizen through disciplinary techniques, for example accepting MCRT intervention when someone is in crisis. It also refers to the population, the object of biopower, as a body – a healthy, safe body – that is governable. Viewed in this way, the crisis (PIC) and the response (MCRT) are a necessary contribution to this production because power includes the practices through which individuals are made visible, come to be known and altered in order to make them productive (Foucault, 1979).

Our analysis shows that various PIC terminologies are used interchangeably, including “consumer,” “vulnerable,” “mental health emergencies,” and “client,” without a clear connection or distinction between them. What is not apparent is the exact link between the behaviours of a person with mental illness, an emotionally disturbed person, a vulnerable person, or a consumer and the crisis. Moreover, it is unclear what the actual crisis is, assuming that there is only one kind of crisis. We propose that the shift toward PIC potentially allows MCRT not only to target individuals with mental health concerns but also expands the definition to potentially include anyone in the population who may appear to be experiencing any type of crisis, however vaguely

this notion happens to be defined. As previously mentioned, in Iacobucci's (2014) definition of PIC, the term is not restricted to a person with mental illness. Iacobucci's (2014) account suggests and rationalizes an expansion beyond traditional categorizations of "mental illness," "substance abuse," and "behaviour disorder," while at the same time including them. Although the crisis experienced may be the result of mental illness, addictions, or behaviour disorder, Iacobucci (2014) explicitly indicates that assumptions regarding the person's mental or emotional condition before the incident are not to be made. That said, police and/or a mental health professional may have existing background information pertaining to the PIC. If a PIC is to be viewed only from the position of 'crisis' then assumptions about their character are redundant and perhaps irrelevant. PIC are made into crisis through the MCRT response because of the assumptions that underlie the MCRT (i.e., that police are the legitimate response).

Calls prompting an MCRT response can be diverse and involve a variety of circumstances, and it is therefore impossible to set parameters around responding solely to individuals with mental illness. When 911 dispatchers receive calls for service, the calls can stem from a description of circumstances (outside of the individual), thus being deemed as potential PIC situations. This ambiguity around the construct of PIC hints at the extent to which the criminal legal system and mental health and healthcare systems can insert themselves into the lives of individuals. Reconstructing individuals as PICs allows MCRTs to access already-identified populations (PMIs) who can be rescued, helped, or guided and also expand to untapped members of the population (those without a mental illness). Stanley Cohen (1979, as cited in Taylor, 2018) points out that in such a scenario, two overlapping processes occur: "A decrease [in] the amount of intervention directed at many groups of deviants in the system, on the one hand, and an increase in the total number who get into the system in the first place" (p.

200) on the other. As a result, MCRT practice may represent a manifestation of a net-widening effect (Cohen, 1991) that operates as a form of systematic predetection (Castel, 1991). In other words, such practices provide the basis for, and constitute the expression of, "practices of disciplining both individuals and populations" (Dreyfus & Rabinow, 1983, p. 153; see also Foucault, 1979).

Given that police officers in MCRTs are responsible for simultaneously engaging both their "specialized role" (Iacobucci, 2014) and police-specific activities, individuals within and outside of the parameters of crisis can become subject to MCRT intervention. Moreover, being framed as active participants in managing wellbeing, PIC are tasked to engage in self-management and when they cannot, the crisis becomes the work of MCRTs to solve and therefore being the solution to the PIC problem. This aligns with a neoliberal paternalistic governance wherein the PIC is at once unable to cope and potentially risky and at the same time "*potentially* recoverable through the technology of [guidance, help, support]" (England, 2023, p. 151; italic in original).

Neoliberal modes of governing give rise to new discourse that construct individuals in new ways, and we have attempted to demonstrate how this operates by examining the category of PIC. By expanding the criteria for intervention under the definition of PIC, anyone can potentially become the subject of MCRT intervention, and the gaze is widened to all facets of the individual's surroundings—in the school, at home, and within the public—because crisis can occur anywhere. Anyone can be watched while at the same time engaging in the watching of others to maintain safety and provide care. In this process, everyone is responsible for, and contributing to, the production of individuals who are both willing and capable of participating in

society (Garland, 2001). However, if in the process of engaging in active citizenship a person experiences a crisis, MCRT can be right there to provide a safety net and “help” you “manage.”

What Is Left Unproblematic in These Representations? Where Are the Silences?

A fundamental issue left unproblematic in the MCRT policy texts concerns the stigma of mental illness. Almost every document analyzed in this study mentions a need to address, eliminate, or reduce the stigma of mental illness (e.g., HSJCC et al., 2023; Iacobucci, 2014; OPP, 2015) and positions it as an aim of MCRTs (HSJCC et al., 2023). We argue that the contradictory language in government policies, which emphasize risk and protection while at the same time claiming to address stigma, demonstrates the subtleties within which structural stigma operates—through the very policies that are designed to address it and through the risk to self and others that a population presents.

Our WPR analysis supports these claims by considering the ‘crisis’ in PIC. We show that risk and danger are implicated within the broad language of ‘crisis’ yet the targets of intervention continue to be those traditionally deemed to be risky (people with mental health and addictions concerns). Although PIC are more likely to experience violence than perpetrate it, we (broadly speaking) continue to posit that they are risky. The insistence that PIC are risky and dangerous is obscured by the label ‘crisis’ and at the same time advanced through the language of risk and danger itself and used to rationalize that PIC may be a public safety threat. The fear that this population will cause harm to themselves, or others thereby legitimizes police—the authorized users of state violence—as the appropriate responders to PIC. At the same time, crisis can now also include the *potential* of risk and expand to include the broader population (because anyone can be in crisis). In other words, the crisis category puts risk and danger in the background, makes it more discreet yet applicable on a bigger scale. Viewed this way, the language of risk

and risk management policies, then, continue to be positioned as a rational solution to the problem. Consequently, in this process, the stigma of mental illness is silenced and perpetuated; policies do not have to confront or address stigma as an institutionalized phenomenon and, instead, police become reaffirmed as the protectors between the "normals" and the "Others."

Within MCRT policy, we also see a distinction between how stigma of mental illness is conceptualized at the level of police. For example, police officer mental health is positioned as unique, which we take to mean unique compared to the rest of the public, and therefore MCRT intervention is applied in biased ways. In blatant statements about first responders, the Ontario government positions them as "frontline heroes" (Office of the Premier, 2020, para. 14) who have "unique needs when it comes to mental health and addictions services due to work-related stress or trauma" (Ontario Health, 2022, para. 1). As a response, the government aims to provide mental health care to first responders (i.e., police) "to better understand their unique needs and stressors and identify appropriate services to support their health and wellness" (Ontario Health, 2022, para. 3). Two common mental health challenges these "brave women and men" (Office of the Premier, 2020, para. 14) are said to experience are posttraumatic stress disorder (PTSD) and occupational stress injury (OSI).

By attributing the mental health issues of first responders as a byproduct of their job, or an occupational hazard, their mental health (and illness) is explained away by conditions of their job; it is their job that is risky (in other words, the risk is "out there"). This distinction absolves police officers from any association of their mental health status with the stigmatic attribute of "risk." This way, mental illness (regardless of the "acceptable" terminology used to name it) continues to be associated with particular groups of people (i.e., the ones that are not the police). Moreover, mental illness is not in fact destigmatized (or decriminalized) because doing so would

require governments and police to admit that police officers may themselves fall within the PIC category, irrespective of their job. As long as it is *the job* that is risky and not the police themselves posing a risk and danger, governments do not have to do anything to destigmatize or decriminalize mental illness. If police were required to admit that they belonged to a "risky" group, they would also need to be viewed as the dangerous subject who poses a risk to public safety or who may be a danger to self and others.

Our attempt here has been to show that crisis can be, and perhaps requires to be, considered as the discreet way through which structural stigma is perpetuated in MCRT policy. It is discreet in the context of crisis because crisis can be anything. Importantly, if the governmental project is aimed at the population, then crisis (within which risk is embedded but more subtly) is the mechanism through which structural stigma can be diffused and operate. At the level of the individual, we observe that the stigma of mental illness is viewed and/or understood differently for individuals traditionally categorized as mentally ill than for police, resulting in competing approaches to its management. For PIC, mental illness continues to be 'within' while for police it is 'out there'. We present that these distinctions enable police to retain their legitimacy and, in some ways, a victim of circumstance (of their job) while PIC are the risky and dangerous "Other." More importantly, this distinction disguises the many dangerous police behaviours resulting in deaths of PIC. Lastly, these distinctions perpetuate contemporary destigmatization campaigns which hold the assumption that "by reducing or eliminating stigma we will improve the everyday lives of these marked individuals" (Hannem, 2021, p. 201). In other words, these campaigns focus on:

> The symbolic and relational aspects of stigma without considering the structures, policies, and interventions built up around stigmatized groups that mark them as outsiders – as "risky" or "at risk" and in need of intervention. That is, destigmatization is often understood

> as something that can be accomplished at an individual, rather than at a structural level (Hannem, 2021, p. 201).

Lastly, we also posit that the contrast between mental health of police and that of PIC, reflects what Foucault identified as dividing practice and we take up its effects in the next section.

What Effects Are Produced by This Representation of the "Problem"?

This question of the WPR approach engages in "political conversation about where particular problem representations have led and are likely to lead" (Bacchi, 2009, p. 43). Here the focus is on recognizing that how the problem is represented has implications for "how the people involved are treated and are evoked to think about themselves" (Bacchi, 2009, p. 1). The intention is to explore the discursive effects, lived effects, and subjectification effects (Bacchi, 2009) of a given problematization or way of thinking, both for policy and for people's lives.

Subjectification effects position groups of people in opposition to one another and are reflective of what Foucault (1982) calls dividing practices. Dividing practices shape who is responsible for the "problem" and what is silenced in the "problem" (Bacchi, 2009). For example, crisis distracts attention from the conditions that give rise to crisis in the first place, and the dissolution of the subject—that is the "at-risk" individual— "deflects attention away from the socioeconomic underpinnings of risk, and divorces misfortune from questions of social justice" (Lupton, 1999, p. 103). By examining lived effects, the researcher aims to understand how policy discourse impacts people "in the real" (Bacchi, 2009, p. 18); in other words, how the effects of discourse are experienced in daily life. For example, in our discussion of structural stigma, we suggest that mental illness will be neither destigmatized nor decriminalized if police officer mental health is not represented as a threat, risk, or danger to self and/or others.

Given that we have addressed discursive effects and touched on lived effects in other areas, in this section we draw attention to the third type of effect: subjectification effects/dividing practices (Bacchi, 2009). Dividing practices examine how governing practices position groups in opposition as a means to facilitate rule (Bacchi, 2009; Foucault, 1982). In other words, by positioning groups and people in opposition (i.e., normal vs abnormal), dividing practices also produce the manner in which they will be governed. In the context of MCRTs, dividing practices manifest in several ways. First, in Question 1, we examined the policing problem, which positions the police and mental health workers in differing ways. Despite being positioned in a supporting role to the mental health practitioner, the police are at the same time granted the ultimate authority in determining the outcome of the interaction with a PIC (HSJCC et al., 2023). As such, police and mental health professional partnerships have the potential to engage in criminalization and reify police as the protectors of safety, potentially silencing the mental health worker (De Shalit et al., 2022).

Dividing practices also occur at the level of MCRT expansion. The government has positioned and funded police-led MCRTs against non-police-led MCRTs because the former "are best positioned to respond to [people in crisis]" (Solicitor General, 2022, para. 2) under the guise of public safety. The creation of the PIC category delineates between various "types" of PICs— "mentally ill" individuals, people with addictions, neurodiverse individuals, those having a general crisis—each of which can be further categorized by the levels of risk they pose to themselves or others (HSJCC et al., 2023; Iacobucci, 2014). PIC are also positioned against the categories of "consumer," "survivor" (particularly when positioned as an empowering term; HSJCC et al., 2023), "vulnerable," and "stigmatized." Consequently, the passive patient is transformed into a health consumer and actively engaged in the administration of their wellbeing.

The client/patient is reconceptualized as a consumer in the free market. As a consumer, the individual is (or should be) now able to choose the types of services that will best meet their needs. However, as we have seen, the same process through which the PIC is produced is the same one that decentralizes state authority "and reinstates its ability to intervene" (De Shalit, 2021, p. 121).

Last, we would like to point out the positioning of first responders in juxtaposition to PIC. As noted above under the analysis of Question 4 ("What Is Left Unproblematic in These Representations? Where Are the Silences?"), first responders are positioned as heroes with unique needs and stressors when it comes to mental health and addictions (Ontario Health, 2022; Office of the Premier, 2020) who need to be protected: "Our government continues to ensure that we protect the brave women and men on the frontlines, and ensure[s] they have access to the supports they need, when and where they need them" (Office of the Premier, 2020, para. 14). This positioning takes place in contrast to a PIC, who is described as "sufficiently erratic, threatening or dangerous" (Iacobucci, 2014, p. 49). We bring this to attention to raise three points, but which will require further scrutiny in subsequent studies; for now, our intention is to point out the contradictions and potential consequences.

Our first main point is that in positioning police as heroes and PIC as dangerous "Others," police retain not only their legitimacy but also obscure their dangerousness. By this, we refer to the numerous shootings of PIC by police, the targeting of racialized, Indigenous, and otherwise marginalized people by police and, in the case of MCRTs, the police authority to determine outcomes of interactions (HSJCC et al., 2023). The second main point we wish to bring to attention is the positioning of police as experiencing mental health challenges, framed as PTSD as a result of their job, while PIC retain the mental illness pathology coupled with

assumed risk and danger. We posit that placing mental health as outside of the police body and mind removes questions about police as potentially mentally ill, posing a risk and danger to themselves and/or others. Furthermore, if mental illness is removed from within police, it facilitates the thinking about police as protectors and as the carriers of knowledge that 'the other' does not have and which legitimizes them as experts. It also functions to separate police from the "Other" in the context of mental illness, because if we thought about police as mentally ill and therefore dangerous, we would have to confront the various strategies that work so hard to uphold and maintain this silence. The third point we wish to make, and which connects to the second, is that if we saw police and PIC as the same, then it would require affording PIC the same dignities that police receive by way of being police. This includes recognizing the impact of unequal positions within which they are situated and which are traumatizing (as police are afforded the experience of PTSD as a consequence of their work); the legitimacy of their identity as human beings without the marks of risk, stigma, and danger (as police are automatically granted because they are the police).

How can the Problem Representation be Questioned, Disrupted, and Replaced?

This section draws on WPR Question 6 and includes Question 3 (Bacchi, 2009) to identify alternative ways that the "problem" can be conceptualized. The intention of Question 6 is to show points of resistance or how the "problem" can be thought about differently. In this section, we draw on two findings in our study, first, that crisis response is not what police do and the second is that the purpose of MCRTs is to reduce contact with police. These findings signal the contradictions within policies designed as solutions to problems which, consistent with WPR, recognizes "that discourse is plural, complex and, at times, inconsistent" (Bacchi, 2009, p. 19) and we add, never complete. Viewed in this way, the space within contradictions offers

opportunities to engage in counter-discourse. We also draw on literature pertaining to alternative, non-police models of crisis response to present alternative problem representations. Specifically, we draw on the recent report by Human Rights Watch (HRW) titled *Mental Health Crisis Support Rooted in Community and Human Rights: A Case Study* that speaks directly to the ways in which the problem representations discussed in this study can be disrupted.

Reducing interaction with police and the criminal legal system

An important finding that offers insight into contradictions within MCRT policy is the goal of MCRTs in the first place, which is to reduce the time that police spend responding to PIC and is identified as better suited to be addressed by mental health professionals (Solicitor General, 2022). If the rationale is that responding to PIC is better addressed by mental health professionals, then it raises a fundamental question about why MCRTs are funded within police, and simply, why police. This contradiction is highlighted in our findings which indicate that police have come to be viewed as the de facto mental health response, which is traditionally not their job (Iacobucci, 2014) and that police are unable to manage these situations (Solicitor General, 2022). Yet, at the same time, the government intends to stabilize the mental health system by implicating the criminal legal system within it (Ontario Health, 2022; Deputy Premier Elliot, as cited in Office of the Premier, 2020). The intent to reduce interactions between police and PIC while simultaneously legitimizing police within mental health reflects the statement that mental health is neither destigmatized nor decriminalized.

Our analysis shows that when PIC are viewed as risky and dangerous while at the same time as a victim, consumer, and/or survivor, it contributes to the production of the PIC as a subject, bearing marks of stigma, and divorces them from their humanity (through these labels). The labels also make crisis response more convoluted: if PIC pose a risk then it could warrant

apprehension; if they are viewed as a survivor, then they may receive attention in the community.. Accordingly, Balfour and Zeller (2023) state that if crisis is used interchangeably with emergency, wherein "[b]ehavioral health is used to encompass both mental health and substance use disorders and services, [then] the expectation is that all crisis services can address both" and need not rely on language that positions PIC within a criminal legal lens (p. 19). In other words, the crisis label is a site of resistance whereby danger and threat can be contested and rejected such that police will not hold the monopoly over crisis response.

Another consideration we wish to point out pertains to legitimizing police within the mental health system as a site for resistance. Our findings suggest that Ontario still does not have a mental health system – an independent system from health and police – instead, it becomes absorbed within these other systems. We are not suggesting that the creation of another system will fix a systems issue, in fact it would likely reproduce these same dynamics. However, research indicates that as long as police continue to be the default 911 mental health emergency response system, the likelihood of incarceration and death is maintained if not enhanced (Balfour & Zeller, 2023). Also, as long as mental health professionals are absorbed within police-driven crisis response models or rely on hospital psychiatric services for care while community mental health services remain the patchwork of services, the PIC will continue to ping pong between broken systems.

Rights-based approach to mental health

While completing this study, Human Rights Watch (HRW) released its report in November 2023, presenting a rights-based approach to mental health that promotes choice, informed consent, and agency. It reflects a person's needs and aligns with international human rights law. This strategy involves moving beyond harmful coercive approaches that are justified

by language of danger to self and/or others. The report draws attention to the power imbalances when police are first responders to PIC, which are magnified for Black, Indigenous, and racialized people who have traditionally experienced higher rates of violence and mistreatment by police (Ghelani, 2022). Use of force in such cases is in violation of international treaties and standards (HRW, 2023). The report further draws attention to governmental culpability in claiming that community mental health services continue to be underfunded such that mental health crisis response is prioritized as a policing responsibility.

Consistent with the WPR approach, the human rights approach to mental health crisis response disrupts assumptions about PIC and their subject positions. First, in contrast to assumptions about danger and risk by PIC, the HRW approach recognizes the legal status of a PIC as a citizen with rights. Second, because language and assumptions about risk and danger are removed, it displaces the coercive practice of arrest under the MHA when responding to a PIC. For example, within the MCRT approach, if the individual presents in a state of crisis such that compliance is not secured, the PIC can be apprehended under the MHA and brought to the hospital (Iacobucci, 2014). If the PIC is viewed as risky, police make the ultimate determination about the outcome of the interaction (HSJCC, et al., 2023). In contrast, the Gerstein Crisis Centre approach prioritizes the individual and right to refusal of services and the right to change their mind (HRW, 2023). The HRW approach also disjoints the subject position of the PIC as risky and dangerous. In this approach, the focus is not on immediate de-escalation and stabilization (i.e., to return to the pre-crisis state) and instead recognizes that the crisis encompasses conditions such as discrimination, structural racism, and which includes the consideration of housing, food, and other needs (HRW, 2023). In other words, the subject position is disrupted from risk and danger to a rightsholder. Moreover, the HRW approach operates on the recognition

that a power relationship exists between the PIC and professionals and attempts to challenge these power relations through agency and consent of the PIC in ways that are in opposition to reactive and coercive responses by the police.

As an example of a human rights-based approach to mental health crisis response, the Toronto-based Gerstein Crisis Centre provides alternative mental health support to PIC and 24/7 crisis support (HRW, 2022). In previous sections we have identified that police, by way of their first responder role and 911 response, as default responders to PIC (HSJCC et al., 2023; Iacobucci, 2014; Ontario Health, 2022). The Gerstein Crisis Centre, instead, includes (a) the colocation of a crisis worker in the 911 call centre, directly linked through the 211 helpline that anyone can call; (b) a mobile crisis team that responds to a 211 crisis call; (c) crisis beds operating outside of the hospital setting; (d) short-term follow-up support; and (e) recovery programs facilitated by people with lived experience of mental health (HRW, 2023, p. 18).

Our intention in highlighting the HRW approach to mental healthcare and the Gerstein Crisis Centre as an example is to demonstrate the ways through which power relations can be disrupted and to draw attention to human agency in the process. As mentioned in the introduction to this study, our goal is not to judge whether these services are and/or will be effective. There is a plethora of research that is consistent with challenging risk, danger, and care and which aims to de-police healthcare and mental health services (see for example, Balfour & Zeller, 2023; Black, Lo & Gallagher, 2022Carol, et al., 2021). Instead, our intention is to identify ways that dominant problem representations can be disrupted and the HRW approach is one way that MCRT assumptions and subject positions can be disrupted.

Conclusion

This study drew on Bacchi's (2009) WPR approach to examine Ontario's expansion of MCRTs, where 28 police services across Ontario are set to receive the millions of dollars allocated to implement and/or expand them. We sought to critically examine this expansionist agenda and "problematize (interrogate) the problematizations uncovered in public policies through scrutinising the premises and effects of the problem representations they contain" (Bacchi, 2009, p. 265). Our goal was to understand how governing takes place by excavating the problem representations within Ontario Government's expansion of MCRT policy.

We find that MCRT's converge criminal legal, health and mental health systems to deploy disciplinary interventions but with population as the objective. The redefinition of people with mental health concerns, and really anyone, through more inclusive terms such as PIC enables MCRT to be deployed to greater subsets of the populations and shape them into manageable subjects. Although it is arguable that marginalized populations will continually be subject to the gaze of mental health, health, and criminal legal professionals – it expands the criteria to potentially target any individual within a population who experiences a crisis and calls 911 for 'help'.

The knowledge gained through risk assessments that are required of MCRTs and within the parameters of community safety and well-being are reproduced and disseminated as a measure of health and well-being of populations. Moreover, individuals in contact with MCRT are encouraged, through referrals to additional community resources, to obtain further support from these experts to remain 'risk-free' and maintain their place in the community. Those who do actively participate in the process of accepting responsibility for their mental health, manage their crisis and 'feel better', reinstate their place within culturally determined goals and values. Those who do not will have failed in demonstrating self-awareness, will or the "right attitude"

and will be subjected to more directly coercive (non-voluntary) mechanisms – apprehension under the MHA or under the criminal code.

Through MCRT, any individual who is in crisis becomes engaged in the production of the docile body as a free, responsible/responsibilized individual. At the same time, by partnering institutions of social control, it allows for readily-available, rapid deployment of the state's disciplinary technologies to help manage various aspects of life when a crisis occurs – acting as a type of safety-net for those functioning in territories of exclusion. Thus, the state maintains its traditional control functions and at the same time expands them by activating inter-agency-cooperation. An even greater issue, we argue, is that the above techniques and technologies conceal the power relations embedded within these practices and fail to address social conditions that give rise to individuals being in crisis in the first place – which are in fact the ultimate barriers for social success for individuals, especially those who are marginalized. Instead, what we have is a society encouraged to participate in their own subjectification – control disguised as social security and well-being.

The role of MCRT, it can be said, is to reinstate the PIC to their pre-crisis state while providing opportunity for additional support aimed at internalizing medical/therapeutic notions of self-representations and identity. The return to pre-crisis state fails to consider the social inequalities (poverty, lack of affordable housing, unemployment) that perpetuate the crisis and instead are encouraged to participate in their own subjectification—control disguised as social security and wellbeing (Foucault, 1980, 1982). To engage in resistance against such discourses, a human rights approach to mental health provides an alternative account of mental health service delivery. Backed by human rights laws, human agency, and consent, alternative approaches to

police mental health crisis response open an opportunity to challenge perceptions of mental illness and policies that perpetuate structural stigma.

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Table 7

List of Documents Used in the Analysis

Year	Title	Source	Type
2023	*New Mobile Crisis Response Teams: A Framework for Ontario*	Ontario Association of Chiefs of Police	Press release
2023	*Developing Mobile Crisis Response Teams: A Framework for Ontario*	Human Services and Justice Coordinating Committee et al.	Policy document
2023	*Ontario Investing in Mobile Crisis Response Teams*	Solicitor General	Press release
2022	*Ontario Expanding Mobile Crisis Response Teams*	Solicitor General	Press release
2021	*Community Safety and Well-Being in Ontario: Booklet 2—A Snapshot of Local Voices*	Ministry of the Solicitor General	Policy document
2021	*Community Safety and Well-Being: Booklet 3—A Shared Commitment in Ontario*	Ministry of the Solicitor General	Policy document
2020, 2022	*Roadmap to Wellness: A Plan to Build Ontario's Mental Health and Addictions System*	Ontario Health	Policy document
2020	*Ontario Expanding Mobile Crisis Response Services to Respond to Mental Health Emergencies*	Office of the Premier	Press release
2020	*Ontario Budget: Ontario's Action Plan: Support, Protect, Recover*	Ministry of Finance	Policy document
2017	*Police Interactions With People in Crisis and Use of Force: OIPRD Systematic Review Interim Report*	McNeilly (Office of the Independent Police Review Director)	Report
2015	*OPP Mental Health Strategy: Our People, Our Communities*	Ontario Provincial Police	Policy document
2015	*Police Encounters with People in Crisis*	Iacobucci	Report
2011	*Open Minds, Healthy Minds: Ontario's Comprehensive Mental Health and Addictions Strategy*	Ministry of Health and Long-Term Care	Policy document

Chapter 5: Conclusion

The three studies that make up this dissertation, Chapters 2–4, provide a diverse approach to examining CRTs as a policy solution to people in crisis (PIC) overusing the emergency department (ED) and encountering police more frequently. These approaches, although comprehensive, are never fully complete: Knowledge production is neither universal nor deterministic; it exists within the cultures and societies in which it is produced and must always be placed under investigation. My aim in this dissertation was to present multiple ways that CRT policy can be studied, about what is known and what can be known about CRTs depending on the approach used to examine them, and to create space and opportunity for disrupting these knowledges and this practice. In this concluding chapter, I provide an overview of the findings that I derived from the three studies. I also discuss the theoretical, methodological, and substantive contributions, as well as address implications for theory, policy, and practice. Finally, I introduce considerations for future research informed by the studies undertaken in this dissertation.

Principal Findings

My doctoral research provides several key findings about CRT policy that were generated across the three studies. **First,** unresolved structural conditions produce system- and individual-level challenges that contribute to forming CRTs. Features of CRTs reflect system and policy goals related to addressing PIC. Yet because CRTs do not address overarching structural issues, their effectiveness on outcomes are at best mixed. Despite this mixed evidence, CRTs are difficult to refine or replace with models that may generate better outcomes. The first study (Chapter 2) used the critical interpretative synthesis (CIS) method to draw on a broad array of research about CRTs to extend knowledge about these teams. Moreover, by incorporating agenda

setting (Kingdon, 2003) and 3i+E (Gauvin, 2014) policy frameworks, as well as established health and social systems arrangement taxonomies to map, organize, analyze, and interpret the research findings, I locate CRTs across structural (policy legacies), systems (police, health system, and social services) and individual (PIC) processes that point to a concentration of CRTs adapted over time at the systems level. Additionally, the use of the taxonomy advances the analysis of features of CRTs by locating them within governance, delivery, financial arrangements, and implementation considerations. Doing so presents opportunities for clear ways of documenting the various components of CRTs, which may be beneficial for development and evaluation of CRTs that align more closely with current evaluation standards.

Second, the dominant structural interests of police and health institutions inhibit policy alternatives that challenge the status quo. Study 2 (Chapter 3) goes directly to the source, so to speak, to ask the key decision-makers who developed and implemented the MCRRT how and why MCRRT was the policy choice. I found that structure is deeply implicated within policies. This is not to say that structure determines policy, although it may appear that structure operates in a top-down manner *as* policy. Structures, and thereby dominant structural interests, are advanced through processes and networks that shape societal behaviour (e.g., laws, guidelines, punishments). The location of structure within policy, however, produces particular effects. In Study 1, these effects were shown to be the unaddressed, immediate, and chronic needs of PIC. In Study 2, I found them to manifest in the form of a lack of organized interest group opposition to MCRRT. This is not to say that interest group opposition did not exist: MCRRT was developed and implemented at the height of Black Lives Matter protests to #defundthepolice, sparked by high-profile shootings of PIC during interactions with police.

Third, in Study 3 (Chapter 4) I found that official government discourse about expanding MCRTs positions the status quo as a policing, public safety and well-being, and coordination problem. These problem representations not only reinforce traditional assumptions about risk and danger (e.g., that people with mental illness and addictions issues are dangerous to themselves and others) but also expand the representation beyond illness and addiction to include a new risky population: PIC. In my analysis, PICs are at once understood as individuals with mental health issues and in crisis, but also as a population that poses a risk to themselves and others; is vulnerable, stigmatized, and criminalized (or potentially criminal); and uses mental health services. These understandings sit in tension with one another and make it difficult to serve this population in ways that do not exacerbate stigma and negative outcomes.

Fourth, I found that implicated within MCRT policies are neoliberal modes of governance wherein the state disperses its powers and deploys its control not in a top-down fashion, but rather *through* several layers involving community, society, and individuals. Here, the reader can trace the echoes of overarching structural conditions discussed in Studies 1 and 2 that make it challenging to consider alternatives. A stark contrast of Study 3 in relation to the previous two studies is the departure from interpretivist approaches to policy analysis, such as agenda setting (Kingdon, 2003), toward poststructuralist approaches that build on the work of Foucault (1979), such as what's the problem represented to be? (WPR; Bacchi, 2009). Deploying these contrasting approaches allowed me to study the problem from multiple directions. In Study 1, I was able to gather research about how CRTs are formed (problem representation, implementation and outcomes) which in 2, I was able to gain insight from decision-makers about ow they defined the problem (such that MCRRT was the solution), whereas in Study 3 I worked

backward from the solution to which a given problem is represented to be to produce CRT policy problematizations.

Study Contributions

This dissertation makes several contributions to literature on CRTs. The theoretical, methodological, and substantive contributions are derived from diverse and at times competing policy analysis perspectives. My intention in drawing on these diverse approaches reflects (a) the interdisciplinary approach to the study of policy embraced in the health policy PhD program, (b) my background as former mental health practitioner including mental health crisis responder, (c) my academic background in policing, security, criminology, and social work; and (d) the contradictions that encompass each of those factors. It was not my intention to tease out or make sense of the contradictions inherent across these experiences, just as my intention in applying the various theoretical and methodological approaches was not to work out their competing ontological and epistemological underpinnings. Instead, my hope is that the array of approaches in this study are regarded broadly as an engagement in reflexivity.

Theoretical Contributions

In this dissertation, CRTs were examined through various approaches to policy analysis including a critical interpretive lens (Study 1, Chapter 2), interpretivist lens (Study 2, Chapter 3), and poststructural policy analysis (Study 3, Chapter 4). This comprehensive approach to studying CRTs advances the role that CRTs play within and across domains of state, structure, systems, and individuals. **First,** the conceptual framework developed in Study 1 offers valuable insight into the concentration of CRTs at the system level and the problems this produces (and reproduces), including how CRTs perpetuate structural conditions without addressing the chronic individual needs of PIC. Scholars interested in the contested spaces of structure and agency

might benefit from applying my findings in ethnographic research on CRTs. Additionally, by incorporating the health and social systems taxonomies in the CIS, CRTs features are reframed as governance, delivery, and financial arrangements and implementation considerations. This new conceptualization provides an opportunity for learning about and improving such models to optimize their outcomes based on data and evidence. Lastly, the conceptual framework developed in Study 1 (Chapter 2) provides an update on the status of CRT literature, if only to reveal concerns about the plethora of studies completed on CRT that draw on diverse methods only to produce similar results.

Second, drawing on agenda setting (Kingdon, 2009) and 3i+E (Gauvin, 2014) in Study 2 provides insight into how decision-makers frame problems to which they propose solutions. The main theoretical findings include the role of structural conditions that shape policy choice. This study is a good example of incremental theory of decision-making which posits that alternatives that are considered for policy adoption tend to draw on existing structures. In accordance with findings from study 1 that show the role of structure in shaping policy, study 2 substantiates this theoretical finding and incrementalist decision-making in two ways. First, structures such as policy legacies create capacities and resources and learning for future policy development such that police and health institutions were able to design their proposal within existing structures in ways that incrementally build on these processes without drastically altering them. This further shows that rather than making ‘big bang’ changes in policy, smaller changes tend to be more digestible. The second consideration is the role of structure in shaping interests. Powerful interests aligned without dramatically affecting dominant structural interests. MCRRT provided a way to address problems in both systems while avoiding conflict and resistance from powerful interests. These theoretical insights provide a pragmatic, albeit complex, insight into policy-

making and as such, while I was able to see structure at play in the policy-making process, structures do not determine the outcomes – this provides an important insight into the role of structure and agency in policy-making whereby structures may shape decisions but they do not determine the decision and as such, MCRRT was able to introduce the first responder element to CRTs.

Third, the WPR approach (Bacchi, 2009) creates space for critical policy analysis of MCRTs. This is particularly timely as the Ontario government recently announced the expansion of MCRTs, with funding being allocated to police services across 28 jurisdictions in Ontario (Solicitor General, 2022). Two key theoretical insights in this study are that when problematizing PIC, it reveals the risk and protection discourses that are encompassed within that enable PIC and populations to be governed. And, although risk and protection discourses are not new, this problematization of PIC is because it provides additional insight into how structural stigma operates in new ways. For example, structural stigma, which is mediated through risk as it relates to a traditionally defined stigmatized individual, PIC, by encompassing the individual and the population, introduces new conceptualizations about ways that populations can be governed through stigmatizing policies.

Methodological Contributions

The key methodological contribution in this dissertation is the combination of established methods, the CIS, case study, and critical policy analysis, that allowed for a unique, integrated and interconnected methodological approach to interrogate the policy domain of CRTs. First, although various reviews have been done on CRTs, the utility of the CIS method to look at the data in other ways was crucial to (re)designing and synthesizing features of CRTs which has the potential to be used as a tool when developing CRTs. The CIS also helps inform how structural

conditions that shape system level capacities for reform make considering alternative responses to CRTs difficult and may perpetuate ineffective polices and miss opportunities for transformative change. Second, using case study approach in Study 2 (Chapter 3) allowed me to examine the 'unique' case of the MCRRT model, in Hamilton, Ontario which offers insight into incremental decision-making showing that decision-makers tend to adopt practices by drawing on existing structures rather than disrupting powerful interests. Third, the WPR approach deployed in study 3 (chapter 4), enabled me to excavate a key problematization in policy discourse, that is the PIC as a subject. This ensures that researchers remain uncomfortable with their approaches because of the insights that looking beyond comfort, can show. These studies are also strengthened by the diverse approaches because they show the complexities in what may be viewed as pragmatic policy-making and complicating them further through critical policy studies and therefore create spaces of disruption. In many ways, the theories, methods and tools in this dissertation allowed me to be reflexive in studying CRTs.

Substantive Contributions

Several substantive contributions are derived from this dissertation. Study 2 (Chapter 3) provides insight about how decision-makers can strategically align their proposals within existing government directives in ways that incrementally build on existing structures and processes. The findings also provide a useful reference for aligning ideas within the context of structural interests to implement a program. Next, the WPR approach to policy analysis reminds students, practitioners, and scholars that problems do simply exist 'out there' waiting to be discovered and defined. Rather, the WPR approach positions problems as shaped and defined by policy which produce effects "in the real."

Additionally, in the study of CRTs the CIS enabled me to comprehensively examine the conditions under which they are formed, their features and their outcomes by incorporating policy analysis frameworks and health and social system taxonomies as a way to map, organize, and interpret the data. Specifically, what is questionable is whether CRTs by way of their concentration and adaptation within the systems domain address either of the two domains; findings from our CIS suggest that they do not. Our findings indicate that because CRTs do not address overarching structural issues, their effectiveness on outcomes are at best mixed. Despite mixed evidence, CRTs are difficult to refine or replace with models that may generate better outcomes. These adaptations and policy legacies make it challenging to consider alternatives, especially in the absence of a commitment to learning and improvement cycles aiming to change features of such models over time to optimize outcomes based on data and evidence

Strengths and Limitations

A key strength in this dissertation is the multidisciplinary approach including theoretical and methodological approaches that provided me the opportunity to examine the policy domain through various lenses; it provided an opportunity to question what is known, what can be known about a policy by using these tools. As a growing researcher, these diverse tools open opportunity to question policy concerns in new ways and at times in contradictory ways.

There are also two limitations that require consideration. First, notably absent from this dissertation are PIC. A major limitation of CRTs is that they are developed, funded, adopted and evaluated by police (and health institutions) without including PIC themselves nor the communities within which they are implemented. In some ways, this dissertation may reflect these problematics by not including PIC. My intention in not including PIC stemmed from 'seeing' structure as deeply problematic and manifesting throughout my findings. As such, my

intention was to bring structure into light as a way to offer a space to begin dislodging it. Second, I was concerned that my findings including discourse about PIC as risky and dangerous would potentially be harmful (e.g., by asking PIC about their experiences with CRTs while drawing on PIC language in the first place). Instead, the three studies create a space for disrupting structure which can only be done by first showing the ways it manifests in CRTs to then be able to create space of resistance. Moreover, my finding in study 2 brings into tension PIC as a powerful interest group needed to be shown in the context of how structure operates which provides one avenue for mobilizing people with lived experience to require their involved.

Lastly, the discourses of risk and danger and unsafety ascribed to PIC that also need to be shown to highlight that mental illness has not been destigmatized that creates the space for mobilizing people with lived experience to engage in resistance of such discourses. My intention in this dissertation is to make noise of the silences implicated in research and practice that perpetuate structural stigma so that my research can be a tool of disruption and taken up by people in lived experience along with advocates and communities interested in engaging in transformative change.

Second, throughout the CRT literature, several terminologies are used to describe CRTs and their features. Even the acronyms differ. This variation speaks to lack conceptual clarity noted across studies. It also made it challenging to map which features belonged to which acronym, description, and definition of CRTs. It could be the case that potentially relevant literature was inadvertently not captured in the search strategies in Study 1 (Chapter 2). To mitigate this possibility, the search strategy terms were tested with two separate librarians to ensure the search strategies were comprehensive. The search results also show that most of the

studies cited each other's work. This data saturation indicated that the search strategy used in this study was rigorous.

Implications for Policy, Practice, and Research

Findings from this dissertation draw attention to four implications for policy and practice. **First,** a critique of CRT in literature pertains to how they are studied and the ways this is reflected in the literature itself. Literature on CRT consistently points to lack of cohesion in how CRTs are defined or organized within it. This results in ambiguity about what features constitute which model. This is important because first responder models such as the CRT are unique compared to secondary models such as MCIT, which has implications for program evaluation and for policy development and implementation. For instance, how is a decision-maker to know whether a particular CRT model is effective when the model is not clearly operationalized? It would be helpful to have consistency across CRT literature, policy, and practice about what constitutes first responder, what constitutes a secondary responder, and so forth. A proposed approach to attempt consistency in CRT literature can be found in Study 1 (Chapter 2) pertaining to features. **Second,** findings from Study 2 can be useful for decision-makers to strategically align their proposals within existing government directives in ways that incrementally build on existing structures and processes and used when proposing new initiatives that expand on the boundaries of existing programs. **Third,** findings from Study 2 can be used to inform how repressed interests can organize to advance policy initiatives that reflect their needs by organizing in ways that disrupt dominant structural interests. The awareness of the barriers posed by structural interests opens space for disrupting them. **Fourth,** the contradictory language in government policies, which emphasizes risk and protection while at the same time claiming to address stigma, demonstrates the subtleties within which structural stigma operates—through the

very policies that are designed to address it. If structural stigma can be traced back through policy and decision-making processes, by investigating the ways that it operates in interaction between police and PIC, then it may provide insight into ways of disrupting it.

Future Research

Future research attempting to map features of CRTs in a consistent and systematic way might benefit from using the refined approach developed in Study 1. However, more research would be needed to test its applicability. Findings from my dissertation also raise several questions about the effect of CRT policies on PIC. These warrant an independent evaluation, which I hope to examine through postdoctoral work. Specifically, future research on the effect of CRT policies on PIC ought to be examined in four theoretically and pragmatically interconnected domains: (a) to identify and describe how PIC are constituted through policy, discourse, and the media; (b) to understand and describe how PIC negotiate their identity, including resistance to it, in interactions with CRT; (c) to understand and describe the experiences and perceptions of PIC regarding their interactions with CRTs; and (d) to understand and describe how CRT policy manifests during interactions between CRTs and PIC.

Specifically, future research should examine how CRT members take up the ideas and objectives of the CRT policy in interactions or how their actions may contradict or thwart these objectives. Here, structural stigma (Hannem, 2014) provides a theoretical space to investigate the negative consequences that policies may have for PIC. Here, the notion of fear would provide a useful conceptual link between crisis, risk and structural stigma to observe in interaction and to further examine how the interplay of stigma, risk, and fear are manifested in interactions between CRTs and PICs.

Chapter 5 References

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